CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

3 May 1997

Nationwide sleep aid audit starts May 12

NPA to look at 'climate of fear' in pharmacies

Election controversy – candidate will stand

Update: the hayfever season comes early

Council hopefuls tell us their views on PIANA

AAH/Lloyds gets new boss and new group HQ

Hoechst transfers UK OTC brands to Seton

Online at http://www.dotpharmacy.com/

Having a 90% market share would satisfy most companies. But at Canesten we're not content with having the best selling thrush treatment. That's why we're spending £2 million on a new advertising campaign for Canesten Combi. So it won't be just the fastest treatment for thrush, it will be the fastest selling one too.

Canesten®

Abridged Prescribing Information. **Presentation**: One Canesten 1 pessary (containing 500mg clotrimazole BP) plus a 20g tube of Canesten 1% cream (containing 1.0% clotrimazole BP). **Uses**: Pessary for candidal vaginitis; cream for associated vulvitis and to treat the sexual partner to prevent reinfection. **Dosage and Administration**: **Adults** The pessary should be inserted intravaginally, preferably at night, using the applicator provided. The cream should be applied night and morning to the vulva and surrounding area and/or to the partner's penis to prevent reinfection. **Children** Paediatric usage is not recommended. **Contra-indications**: Hypersensitivity to clotrimazole. **Warnings and Precautions**: Medical advice should be sought if this is the first time the patient has experienced symptoms of candidal vaginitis. Before use, medical advice must be sought if any of the following are applicable: More than two infections of candidal vaginitis in the last six months; previous history of a sexually transmitted disease or exposure to partner with sexually transmitted disease; pregnancy or suspected pregnancy; aged under 16 or over 60 years; known hypersensitivity to imidazoles or other vaginal anti-fungal products. Do not use if the patient has any of the following symptoms, whereupon medical advice should be sought: Irregular vaginal bleeding; abnormal vaginal bleeding or a blood-stained discharge; vulval or vaginal ulcers, blisters or sores; lower abdominal pain or dysuria; any adverse events such as redness, irritation or swelling associated with the treatment; fever or chills; nausea or vomiting; diarrhoea; foul smelling vaginal discharge. If no improvement in symptoms is seen after seven days, the patient should consult their doctor. **Side-effects**: Rarely local mild burning or irritation immediately after use. Hypersensitivity reactions may occur. **Use in Pregnancy**: Only when considered necessary by the clinician. If used during pregnancy, extra care should be taken when using the applicator to prevent the possibility of mechanical trauma. **Legal Category**: P. **Package Quantities and Basic NHS Cost**: 1 x 500mg pessary packed in foil, plus a 20g tube of Canesten 1% cream. An applicator for the pessary is included, £4.25. **Product Licence Numbers**: Cream 1% 0010/0016R; 500mg Pessary 0010/0083. **Further information available from**: Bayer plc, Pharmaceutical Division, Bayer House, Strawberry Hill, Newbury, Berkshire RG14 1JA. Telephone (01635) 563000. **Date of Preparation**: July 1995

News this week of further shake-ups in the AAH/Lloyds business gives the clearest indication yet of the way it is likely to be run in the future. Announcements have been coming thick and fast since the German owner, Gehe, announced at the end of March that Holland & Barret was to be sold. The merging of Lloyds and AAH has not been without pain, and the victor in the takeover battle, on the face of it, seems to have borne the brunt in the subsequent reorganisation. Hills' head office is to be relocated to Coventry, with most of its 70 staff being made redundant. Lloyds' retail, purchasing and marketing teams will be retained (as reported in *C&D* April 5) and relocate to the new headquarters from Atherstone. Many will be hoping they put their old corporate culture behind them. AAH Pharmaceuticals, the wholesale arm, is, for the moment at least, left in Runcorn, but will lose its close link with the group head office. Moulding the new organisational structure will take some time, with retailing and distribution changes likely to follow for up to 12 months. The former managing director of Lloyds Chemists, Michael Ward, has survived to head the new company. With Colin Wilson the new group buying director, old Lloyds' hands cannot claim to be poorly represented in the new senior management structure. From the community pharmacy viewpoint, the fact that Hills has brought Lloyds' branches into NPA membership is to be welcomed: the days when Lloyds ploughed its solitary furrow are over. The NPA is understandably delighted, since this considerably strengthens its position as the representative body for community pharmacy. Independents are concerned that it will further erode their voice within 'their' trade association, but time will not stand still, and anyone who believes change is a comfortable process is being naive.

CHEMIST & DRUGGIST

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CHEMIST & DRUGGIST
THE NEWSWEEKLY FOR PHARMACY

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REGULARS

Scottish stats

There were 4,694,446 prescriptions dispensed in Scotland in January with a gross cost of £45 million and a cost to the Exchequer of £42.37m. The cost per prescription dispensed was 949.21p gross or 893.24p net. The figures including appliance suppliers were 958.49p and 902.60p respectively. The cost per person was £8.49 gross or £8.01 net.

Deal on eDTB

The National Pharmaceutical Association has negotiated a discounted rate for members who want the electronic version of the *Drug & Therapeutics Bulletin*, which comes out on CD-ROM twice a year. An upgrade costing £14.25 on top of the existing subscription is offered. A subscription covering both the paper and electronic versions costs £45, a saving of £5.

March stats

There was a net decrease of 21 in the number of pharmacies on the Register during March, bringing the total to 12,223. There were 50 deletions, and 29 start-ups, with one restoration. The deletions included 15 Lloyds Chemists.

Work victims

Female employees are facing increasing risks of assault at work. However, employers are failing to provide support, and lack plans to help workers cope after crime-related violence. This is the view of Victim Support, which drew attention to the subject last week.

Mouthwash

This month's *Which?* has drawn attention to the high alcohol content of mouthwashes, calling for child-resistant caps and a prominent warning for the product to be kept out of the reach of children. It would also like to see the warnings about not swallowing in larger writing, as well as the ingredients list indicating the volume of alcohol.

Mental genetics

The Medical Research Council is asking the public for its views on research into the genetics of mental disorders. The MRC is planning to fund further research into how genes and environmental factors influence behavioural disorders. A booklet invites people to comment on the worries they have about such research. Copies are available free from the MRC, tel: 0171 636 5422.

Sleep aid audit next week

Community pharmacists are being encouraged to participate in a nationwide audit of over the counter antihistamine sleeping aids.

Details of the two-week National Confidential Audit, which will run from May 12-26, have been sent to all community pharmacies by the Royal Pharmaceutical Society (*C&D* March 15, p6). The audit aims to study how pharmacists respond to requests for named products, particularly as OTC medicines are increasingly marketed directly to the public.

Results will be analysed as soon as possible and participating pharmacies can expect to have feedback on how they compare to the national average within two months.

"The purpose is to give individual feedback, so pharmacists can decide whether they are happy with what they are doing," says David Pruce, audit development fellow at the Society.

He wants as many pharmacies as possible to participate. "We have had a very good response from the multiples and they have all been very supportive," he says. "We want to publish the results to show what pharmacists actually do." The results will also indicate whether any changes in either audit processes or protocols could be made.

Pharmacists will be asked to record three factors on a 'scannable' pro forma when dealing with requests for the sleep aids Medinex, Nytol (and Nytol One-A-Night), Phenergan Nighttime and Sominex, or own-brand antihistamines licensed for adult sleep disorders. These are:

- what the pharmacist knew or found out about the customer making the request
- what was the outcome
- who was involved in the request.

The antihistamine sleeping aids have been chosen as they are advertised directly to the public, who will frequently ask for them by name, and are an area where the pharmacist can intervene. A pilot study had looked at H2 antagonists, but it was found that not enough queries from the public would be generated in two weeks to make the study worthwhile.

As Nytol also has a herbal product, Mr Pruce says that it will not be a problem if this is recorded as the survey is looking at outcomes.

The audit pack being sent out includes recording forms and a question and answer sheet. Further information can be obtained from Mr Pruce at the RPSGB on 0171 735 9141.

Persona comes under 'Watchdog' scrutiny

Unipath was disappointed with BBC1's 'Watchdog Healthcheck' programme last week, which drew attention to the 450 women who became pregnant while using the Persona contraceptive method.

"The programme seemed more interested in talking about the number of pregnancies, rather than putting the figures into context," Rebecca Tan, UK brand manager, told *C&D* on Monday.

The reliability of Persona is 94 per cent, which means that for every 100 women using the method for one year, six would become pregnant as a result of Persona not identifying the fertile phase correctly. This figure was obtained by an independent prospective trial, which included inexperienced users. A comparison trial of the condom gave the same reliability. Ms Tan said that trials showing the condom was 98 per cent reliable were retrospective studies with experienced users.

"About 100,000 Persona monitors have now been sold since launch and we have carefully monitored progress through feedback from our Careline, from Boots and from family planning organisations," said Ms Tan. "Pregnancy levels among Persona users fall well within the parameters of the reliability figure and there is no reason to question the reliability of 94 per cent, which is clearly communicated in all literature and in the pack."

Superdrug trials fax prescription service

A Superdrug pharmacy is trialing a prescription faxing service in Camberley, Surrey.

A promotional leaflet reads: 'Busy schedule? Never enough time at lunch time? Forever dashing to catch a train, bus, lift home? We can help ... Why not drop your prescription into our pharmacy on the way to work or fax it through? Collect at your leisure and avoid waiting problems."

A spokeswoman says the fax service is used mostly by people collecting bulk prescriptions for homes, but it is also available to individuals. If successful, the company will consider making it available through other stores.

Desmospray®

DESMOPRESSIN NASAL SPRAY

April 1997

IMPORTANT INFORMATION

Dear Pharmacist

I am writing to advise you of a number of important changes which affect DESMOSPRAY. With effect from May 1, the DESMOSPRAY formulation, pack size and price will all change.

Formulation

We have developed a new formulation which is room temperature stable. Refrigeration is no longer required. Clearly this has profound advantages for those patients who are continuing to use DESMOSPRAY. You should however draw their attention to this change not only from the point of view of storage but also to the fact that Desmospray is now odour free. This is because chlorbutol, the previous preservative has been replaced with benzalkonium chloride.

Pack size

We have increased the DESMOSPRAY pack size to 6.0 ml. in order to provide 30 days treatment at the bedtime starting dose of one spray into each nostril (20 mcg). In addition to the 6.0 ml content being clearly marked on the packaging, the carton is distinctively labelled "NEW FORMULATION STORE AT ROOM TEMPERATURE."

Price

The new price of £28.00 reflects the increased content and dosage cover which the convenient new formulation provides.

From May 1 the previous DESMOSPRAY 5.0 ml formulation will no longer be available from our warehouse. Wholesalers have been asked to distribute all their existing stock of DESMOSPRAY 5.0 ml before supplying the new product.

Overleaf is Prescribing Information for the new formulation together with Patient Instructions which you may find helpful in discussing this latest development with DESMOSPRAY patients.

Should you have any questions regarding the changes outlined above please do not hesitate to contact me.

Yours sincerely

Yakub Umer
Product Manager

Prescribing information overleaf

FERRING PHARMACEUTICALS
Ferring Pharmaceuticals Ltd.
Greville House, Hatton Road, Feltham, Middlesex TW14 9PX
Tel: 0181 893 1543

IMPORTANT INFORMATION

Desmospray®

DESMOPRESSIN NASAL SPRAY

Name of product: Desmospray, Desmopressin nasal spray. **Presentation:** Desmospray is a metered dose pre-compression atomiser delivering 60 doses of 10 micrograms Desmopressin acetate per spray. Uses Desmospray is indicated for: 1) The treatment of primary nocturnal enuresis. 2) The treatment of nocturia associated with multiple sclerosis where other treatments have failed. 3) The diagnosis and treatment of vasopressin-sensitive cranial diabetes insipidus. 4) Establishing renal concentration capacity. **Dosage and administration** ***Primary Nocturnal Enuresis:*** The starting dose for children (from 5 years of age) and adults up to 65 years of age) with normal urine concentrating ability who have primary nocturnal enuresis is one spray (10 micrograms) into each nostril (a total of 20 micrograms) at bedtime and only if needed should the dose be increased up to two sprays (20 micrograms) in each nostril (a total of 40 micrograms). The need for continued treatment should be reassessed after 3 months by means of a period of at least one week without DESMOSPRAY. During the treatment of enuresis the fluid intake should be limited to a minimum and only to satisfy thirst for 8 hours following administration. ***Treatment of Nocturia:*** For multiple sclerosis patients up to 65 years of age with normal renal function suffering from nocturia the dose is one or two sprays instranasally (10 to 20 micrograms) at bedtime. Not more than one dose should be used in any 24 hour period. If a dose of 2 sprays is required, this should be as one spray into each nostril. During the treatment of nocturia the fluid intake should be limited to a minimum and only to satisfy thirst for 8 hours following administration. ***Treatment of Diabetes Insipidus:*** Dosage is individual but clinical experience has shown that the average maintenance dose in adults and children is one or two sprays (10 to 20 micrograms) once or twice daily. If a dose of two sprays is required, this should be as one spray into each nostril. ***Diagnosis of Diabetes Insipidus:*** The diagnostic dose in adults and children is two sprays (20 micrograms). Failure to elaborate a concentrated urine after water deprivation, followed by ability to do so after the administration of DESMOSPRAY confirms the diagnosis of cranial diabetes insipidus. Failure to concentrate after the administration suggests nephrogenic diabetes insipidus. When used for diagnostic purposes the fluid intake must be limited and not exceed 0.5 litres from 1 hour before until 8 hours after administration. ***Renal Function Testing:*** Recommended doses for the renal concentration test: Adults: Two sprays into each nostril (a total of 40 micrograms) Children: (1-15 years): One spray into each nostril (a total of 20 micrograms) Infants (to 1 year): One spray (10 micrograms) Adults and children with normal renal function can be expected to achieve concentrations above 700mOsm/kg in the period of 5-9 hours following administration of DESMOSPRAY. It is recommended that the bladder should be emptied at the time of administration. When used for diagnostic purposes the fluid intake must be limited and not exceed 0.5 litres from 1 hour before until 8 hours after administration. In normal infants a urine concentration of 600mOsm/kg should be achieved in the 5 hour period following administration of DESMOSPRAY. The fluid intake at the two meals following the administration should be restricted to 50% of the ordinary intake in order to avoid water overload. **Contraindications:** Desmospray is contraindicated in cases of: cardiac insufficiency and other conditions requiring treatment with diuretic agents, hypersensitivity to the preservative. Before prescribing Desmospray the diagnoses of psychogenic polydipsia and alcohol abuse should be excluded. When used to control nocturia in patients with multiple sclerosis, Desmopressin should not be used in patients with hypertension or cardiovascular disease or be prescribed to patients over the age of 65. **Use in pregnancy:** Desmospray should be given with caution to pregnant patients although the oxytocic effect of Desmopressin is very low. **Use in lactation:** The amounts of Desmopressin that may be transferred to the child are considerably less than the amounts required to influence diuresis. **Precautions:** Care should be taken with patients who have reduced renal function and/or cardiovascular disease or cystic fibrosis. When Desmospray is used in the treatment of nocturia, periodic assessments should be made of blood pressure and weight to monitor the possibility of fluid overload. **Special precautions for use:** Precautions to prevent fluid overload must be taken in: conditions characterised by fluid and/or electrolyte imbalance, patients at risk for increased intracranial pressure **Side effects:** Occasional side-effects include headache, stomach pain, nausea, nasal congestion, rhinitis and epistaxis. Allergic reactions to the preservative have been reported rarely. Treatment with Desmopressin without concomitant reduction of fluid intake may lead to fluid retention, hyponatraemia and in more serious cases, convulsions. **Interactions:** Indomethacin may augment the magnitude, but not the duration of response to Desmopressin. Substances which are known to release antidiuretic hormone e.g. tricyclic antidepressants, chlorpromazine and carbamazepine, may cause an additive antidiuretic effect and increase the risk of water retention. **Treatment of overdose:** Overdosage increases the risk of fluid retention and hyponatraemia. If hyponatraemia occurs, Desmopressin treatment should immediately be discontinued and fluid intake restricted until serum sodium is normalised. **Pharmaceutical precautions:** Desmospray should be stored at room temperature (up to 25°C) and must be protected from light. **Legal category:** Prescription Only Medicine. **Package quantity:** 6ml bottle (60 x 10 microgram metered sprays). **Basic NHS Price:** Desmospray £28.00 per 6ml. **Product Licence Number: PL 3194/0024. PL Holder:** Ferring Pharmaceuticals Ltd., Greville House, Hatton Road, Feltham, Middlesex TW14 9PX. **Date of Preparation: February 1997.** Desmospray is a registered trade mark.© 1997 Ferring Pharmaceuticals Ltd. **Date of printing: April 1997.**

NEW FORMULATION

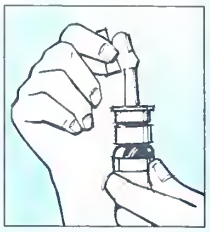


Figure 1

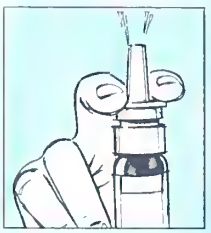


Figure 2

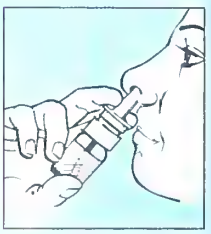


Figure 3

Patient Instructions

How to use DESMOSPRAY Desmopressin Nasal Spray

1: Remove the protective cap. (See Fig. 1)

2: When first used, prime the spray by pressing several times until a consistent, fine spray is seen. (See Fig. 2)

3: With your head tilted slightly back, place the nozzle just inside the nostril. Ensure that the dip-tube is in the liquid when using DESMOSPRAY (See Fig. 3)

4: Hold your breath (DO NOT SNIFF) and press the spray once.

5: Repeat this procedure using alternate nostrils until the prescribed dose is reached.

6: Replace protective cap after use.

7: Store upright at room temperature.

8: If the spray is not used within 7 days of the previous dose, re-prime by pressing the spray at least once before using.

Further information is available on request from:-

FERRING
PHARMACEUTICALS

Ferring Pharmaceuticals Ltd.
Greville House, Hatton Road, Feltham
Middlesex TW14 9PX
Tel: 0181 893 1543

E/023/4/97

New NPA chairman

Left to right: David Thomas, Alan Cruickshank and Gaz Clapinski

The National Pharmaceutical Association's new chairman for 1997/98 is Alan Cruickshank.

Mr Cruickshank has represented Scotland on the NPA Board since 1992 and is currently chairman of the Scottish Pharmaceutical Federation. He takes over from Peter Jenkins.

Gaz Clapinski, who takes over as vice chairman has represented Staffordshire since 1992. David Thomas (West Midlands) was re-elected treasurer.

Price wins in Wales

Cardiff pharmacist Gerald Price has won a two-year fight to save his business.

The battle began in 1994 when Triocare applied for a contract to dispense from St David's medical centre, just 75 yards from Mr Price's outlet in Pentwyn. The application was turned down, but was later granted on appeal to the Welsh Office which thought Pentwyn's 8,000 population could support two pharmacies.

Mr Price then won a judicial review in the High Court which forced the Welsh Office to review the position. The St David's pharmacy opened in October, 1995, but lost the contract nine months later following the judicial review. The Welsh Office has now rejected Triocare's appeal to re-open the health centre pharmacy.

Mr Price said this week: "It's cost a lot of money, but was worth every penny."

He was supported by his customers, who wrote letters of protest to the Welsh Office and boycotted the new pharmacy.

Vision 2020 launched

Dorothy Graham, PSNI president

'A strategy for community pharmacy — the Vision for 2020' was launched to members of the Pharmaceutical Society of Northern Ireland at the Society House in Belfast this week. President of the PSNI, Dorothy Graham, chaired the meeting at which Dr Terry Maguire presented the document to pharmacists, followed by a question and answer session.

Dr Sarah Mawhinney said she believed that fundamental issues were whether pharmacists were prepared to take on responsibility for prescribing and supply of GSL and P medicines, and certain POMs within protocols for registration, as well as medication management and outcome monitoring, including the ability to alter doses within agreed therapeutic protocols. A strong show of hands confirmed the willingness of those attending to work towards these objectives.

On the subject of remuneration for the extra services that would be provided, Dr Terry Maguire commented that it was up to the meeting to agree a vision of community pharmacy for the 21st century and only after that focus on payment.

Terfenadine POM proposals explained

The Medicines Control Agency has issued its consultation letter, MLX 235, outlining the proposals to make terfenadine Prescription-Only.

This supersedes the earlier letter, MLX 225, from August, 1996, seeking to make terfenadine Prescription-Only for children under the age of 12.

Expanding on the Committee on Safety of Medicines advice, the MCA's letter says that there are continuing reports of serious cardiac adverse effects, despite the steps taken in 1992 and 1994 to ensure adequate safeguards. It is also concerned that increasingly complicated precautionary measures are required, such as avoiding grapefruit juice.

Comments on its proposals should be received by June 9, and the change to terfenadine's status should be in effect by August 18, subject to these comments.

Following the CSM announcement last week (*C&D* April 26, p5), the Department of Health held a press briefing on Thursday. While stressing that terfenadine, if used correctly, is safe, CSM chairman Professor Michael Rawlins explained the final factor in its decision to seek POM status had been the evidence of the effect of psoralen, found in concentrated grapefruit juice. This can increase blood levels of terfenadine, with a consequent effect on cardiac rhythm (*C&D* March 8, p10).

Hoechst Marion Roussel, maker of Triludan, says that it supports all initiatives to facilitate responsible usage and will be participating in the consultation process. It has asked pharmacists to ensure Triludan packs contain up to date information.

Novartis Consumer Health says it is also working with the DoH. Only Aller-eze Clear contains terfenadine, other Aller-eze products are not affected. Unichem has responded by printing 300,000 consumer leaflets.

New dotpharmacy pages

Vital need-to-know Drug Tariff and NHS prescription and remuneration information can now be found in a special section on *C&D's* dotpharmacy Internet site.

Courtesy of the Pharmaceutical Services Negotiating Committee, information previously available through 'PSNC News' can now be accessed via the Internet. This includes the information from PSNC's NHS newsletter, up to date NHS script and remuneration statistics for England and Wales, and the current special container and calendar pack list.

Council candidate in 'breach of bylaws'?

A candidate for the Royal Pharmaceutical Society Council elections has confirmed that he will not withdraw after receiving unsolicited support from the Boots Pharmacists' Association.

Even if a breach has been committed, it appears unlikely the Society has the power to rectify the situation.

It emerged last week that Ted Smith, a Boots' area manager, had been endorsed by BPA chairman Peter Walker in the BPA newsletter circulated to Boots' pharmacists two days after official election material was sent out from the Society. It contains Mr Smith's biographical details and his statement of policy.

The Society issued a statement on Monday on the matter: "All candidates are asked to confirm their acceptance of the procedures document at the time they forward their candidature. John Ferguson, secretary and registrar, has written to the candidate asking for his comments."

When asked if he had spoken to Mr Walker about the newsletter, Mr Smith told *C&D* he had made all his comments on the matter in a letter sent to Mr Ferguson on Monday. He stated he had done nothing in contravention of the election procedures.

Asked if he would be standing down, he replied: "Certainly not."

Election arrangements consist of a 'gentleman's agreement' which candidates confirm in writing. If a candidate is thought to be in breach of this, comments are sought from the candidate, which are reported to Council after the election. A candidate cannot be disqualified during the election period.

Council does not have the power, under the current procedure, to disbar a newly-elected member. Council would have to decide to amend the election bylaws to have the power to impose any penalty on the person, but this could only happen "if the candidate knowingly breaches the bylaws".

See also **Letters**, p26.

At the cutting edge of pharmacy

Leading edge pharmacy practitioners and 'soft' networking were discussed at the College of Pharmacy Practice's College Day, held in Kenilworth on April 24

There will be different breeds of pharmacists in the future, said Dr Maureen Devlin, from the National Primary Care R&D Centre. "If you have your own direction, go for it."

She predicted that pharmacists will find it hard to obtain funding for next April's pilots, arising from the 'Choice and Opportunity' White Paper.

"Within the NHS, pharmacists are very immature purchasers," she says. Pharmacists should be striving for:

- further recognition as the 'gatekeeper'
- patients to see the pharmacist before the GP
- effective public relations, including considering the post of a marketing director of the Royal Pharmaceutical Society
- convergence of LPCs.

She proposed a future model of pharmacy divided into three sections: primary care, interface and secondary care. Pharmacists should be able to shift between these areas at will.

Primary care 'High Street' pharmacists would either be contracted to supply only or supply disease management. Prescribing and medicines review could be carried out by a primary care pharmacist not based in the High Street.

Pharmacists at the interface would be involved in purchasing and policy, while pharmacists in the secondary care group would purchase, prescribe and manage disease.

These roles would be carried out by primary care organisations where the pharmacist could be a manager, provider, employee or owner.

In the surgery ...

"GPs' perceptions of what pharmacists can do are very wide," says Dr Gill Speak, an independent prescribing adviser from Bury & Rochdale.

"It's not until you go and show them what you can do that they realise, and this paves the way for more clinical input. Integration with the practice team is an opportunity not to be missed."

The GP/pharmacist interface is still surrounded by fear, prejudice and ignorance. She highlighted pharmacists' own views that practice pharmacists were 'just one more barrier between myself and the doctor'.

Practices prefer having a small but regular pharmaceutical input, rather than a full-time pharmacist. Dr Speak has developed a sessional model whereby she makes a weekly visit to several practices, rather than tackling one practice at a time.

She advocates practices clubbing together to fund a pharmacist. Opportunities include: prescribing support, prescription review, discharge notes, drug information, system review and resource management.

Working in practice is not always easy. "It's the GP not present at meetings who's the one you've got to worry about."

Chairman of the College of Pharmacy Practice David Anderson presented eight new members of the CPP with their certificates at the CPP College Day. They were (back row, l-r): Stuart Lakin, Ray Atkinson, Nick Butler. (Front row, l-r): Michael Line, Tony Moffat, Gillian Hawksworth, Wendy Humphris and Jane Warren. A further 29 pharmacists were successful in obtaining membership

"Leading edge practitioners (LEPs) are pharmacists who see things differently and do things differently. Leading edge characteristics can be developed in a wider group of pharmacists."

Council member Alison Blenkinsopp gave this year's College of Pharmacy Practice annual address on 'Patient advocacy and leading edge practice'.

LEPs not only undertake tasks and adopt behaviours that are noticeably different from others, but they perform tasks better, she believes.

The characteristics which point to leading edge practice are:

- pro-activity/taking the initiative
- 'soft' networking (ie with people)
- patient-centred (taking responsibility to sort things out for the patient)
- influencing GPs
- develop and motivate staff
- take risks with their professional role.

The CPP and pre-registration tutors were seen as possible ways of developing LEPs with appropriate 'soft' skills competence. CPP chairman David Anderson, who is shortly to stand down, said that Dr Blenkinsopp had set the CPP an agenda to follow.

- The CPP is in discussion with the Association of Scottish Trust Chief Pharmacists to link college developments with proposed staged career developments for hospital pharmacists in Scotland.

12 candidates for Scottish Executive election

There are 12 candidates standing for six places on the Royal Pharmaceutical Society's Scottish Executive this year.

Voting papers are to be distributed to pharmacists in Scotland and should be returned by 4.00pm on June 4.

The candidates, with brief biographical notes, are given below.

George Downie of Aberdeen, registered in 1967 – pharmacy manager with Grampian Healthcare NHS trust.

Patricia Duncan of Dundee, registered in 1967 – employee community pharmacist, member of NPAC, member of Scottish Executive.

Eleanor Eunson of Shetland, registered in 1979 – proprietor community pharmacist, secretary Shetland APC.

David Forbes of Banchory, registered in 1969 – member of Scottish Executive, member of SPGC, vice chairman of Aberdeen APC, chairman of Aberdeen CCC.

Ian Johnstone of Motherwell, registered in 1983 – proprietor pharmacist, member of Scottish Executive, member of SPGC standing committee, member of SPF Executive Council, chairman of Lanarkshire APC.

Laura McIver of Bridge of Allan, registered in 1988 – chief pharmacist at Stirling Royal Infirmary, member of PQEB, member of MREC (Scotland), chairman of NPAC.

Clare Mackie of Glasgow, registered in 1982 – community pharmacy contractor, member of APC and GP sub-committee, member of NPAC and DoH review group, chairman of UKCPA primary care development group.

Catherine Mackintosh of Aberlour, registered in 1978 – community pharmacy proprietor, chairman of Moray & Banff Branch, member of local CCC and member of SPGC.

Sheila Paterson of Aberdeen, registered in 1965 – community pharmacist, guest lecturer at RGU, member of Scottish Executive.

Joseph Richards of Coupar Angus, registered in 1973 – senior clinical pharmacist at Ninewells Teaching Hospital, specialist tutor for RGU, member of Scottish Executive.

Dr Sheila Stevens of Drymen, registered in 1972 – company secretary for Bio-images and director of HOST pharmaceuticals, SCPPE tutor, secretary of Stirling & Central Region Branch, chairman of Forth Valley Pharmacy Practice Group.

Alison Strath of Dundee, registered in 1990 – NPA community pharmacy development co-ordinator for Scotland and Northern Ireland, SCPPE tutor, member of HEB, member of Lothian CPP steering group, PIANA co-ordinator, member of RPSGB Pharmacy Audit reference Group, member of Scottish Executive.

N IRELAND NOTEBOOK

Dramatic vision

I avidly read the Pharmaceutical Society's 'Vision 2020' pamphlet, searching for signs of life at 73 University Street. The document gave me considerable comfort that the Council is very much alive and well!

The contents are both stimulating and thought-provoking. Congratulations to the Council for bringing such a bold initiative forward – I didn't think the old girl had it in her! The president will be holding meetings at a number of locations in the coming weeks and I look forward to meeting her, and contributing to the debate.

What Council is proposing, if I understand correctly, is uncharacteristically innovative, and could, if realised, dramatically change the way that we operate. It describes a mode of practice that I have long yearned for, yet look forward to with some trepidation. Will I be able, as a practitioner, to deliver the vision?

I'm not so sure the currently available continuing education will be sufficient to bring me up to the level of competency required for this role, but, in truth, have never looked closely at what is on offer.

The Council is describing a mode of practice that I have yearned for

Council has wisely set its objectives far into the future. It is likely that our medical colleagues will have some comments to make. The idea that the pharmacist will be changing doses and drugs for patients in the future will need considerable selling to a profession that has jealously guarded its clinical freedom.

Nurses are also flexing their clinical muscles in a way that would have been impossible ten years ago. In short, the modern day Florence Nightingales are aspiring to dominate the very roles the Council have identified for us, and they are unlikely to give up their vision to accommodate ours.

Despite these challenges, I wish Council well in its endeavours. I look forward to hearing a fuller explanation of how this brave new world might be realised. Having a vision is one thing; summoning the will, the determination and the strength to bring it to reality is somewhat different. This will allow us to judge whether Council has been, until now, a sleeping giant.

Written by a practising Northern Ireland community pharmacist.

Topical Reflections

MCA needs our advice

Like *C&D*'s editor, I find the current posture of the Medicines Control Agency hard to understand. However, it has asked for consultation over the proposals to deregulate the sale of loperamide, benzoyl peroxide and miconazole from P to GSL status, and consultation is what the MCA should receive.

Every community pharmacist in the UK must reply with a strong rational argument that the expert advice available from the community pharmacy is vital for the effective use of OTC medicines, and that safety alone cannot be the sole criterion.

It may be convenient to have loperamide available over the counter in the local garage, but who will then provide the expert advice that this drug really needs before it can be safely used. Loperamide is on my medicines protocol because I consider it should only be sold after consultation with a pharmacist, but if the MCA's proposals are accepted, then I may as well throw that protocol out of the window.

I believe passionately that medicines should only be sold by a pharmacist or by trained staff under the direct guidance of a pharmacist. The media takes great delight in highlighting the shortcomings of this supervision and the MCA's proposals are, in part, a reaction to this problem. But if today it is loperamide, then tomorrow it could be ranitidine, aciclovir or loratidine, all of which are powerful, effective, but very safe drugs.

The MCA must be heavily lobbied to maintain the credibility of community pharmacy by retaining the P classification, but ultimately the decision rests in all our hands. All community pharmacists must adopt a high profile, come out of their dispensaries and properly supervise the sale of all OTC medicines.

The alternative is an American drug store scenario with no P classification, no pharmaceutical advice, but ever so cheap, cheap, medicines!

Who am I?

Many years ago, when I was an enthusiastic undergraduate, I undertook a project which looked at the public perception of pharmacy and was dismayed to find how poor public understanding actually was.

Many thought that a few years behind the counter at Boots was all that was needed. Some gave me the benefit of the doubt and two A levels. The majority were amazed to learn that pharmacy was a graduate profession.

I had assumed that over the intervening years the public had become more enlightened, but recently a hospital pharmacist criticised public perceptions when his local advertisement for a hospital pharmacist post received a rash of unsuitable candidates.

However, of more concern was a recent advertisement placed in the *Pharmaceutical Journal* on behalf of Co-op Health Care, which required the candidate to be of 'Graduate calibre. Qualified pharmacist'!

If multiple organisations employing pharmacists and advertising in the professional press can show such little understanding of their potential employees' academic and professional qualifications, then I do not consider we have any right to criticise the public for their innocent misconceptions.

I had hoped that the public profile of pharmacy had substantially improved since my student days, but it appears that the educative process still has a long, long way to go!

The best prawn buttie in the land

It is rare indeed for pharmacy to receive accolades from the media, so last week's BBC2 'Food and Drink' programme, where the critical investigations of food additives, pesticides and the supplements industry has now been superseded by the more serious business of tasting the culinary offerings of the fast food industry, provided an unexpected bonus.

Whether it is mince pies, smoked salmon or humble sandwiches, the intrepid reporters from 'Food and Drink' have scoured the land to provide the best in objective consumer reporting. And last week it was the turn of the keepers at London Zoo, who were charged with finding the best pre-packed prawn mayonnaise sandwich.

Third was Sainsbury's, second was St Michael, or was it the other way round? But, no matter, way out in front, and a triumph for pharmacy, was Boots. The best prawn sandwich in the land!

Disallowed dressings

The following have been added to the disallowed dressings and appliances list in the Drug Tariff: Pessaries (flat spring) and Duoderm Dressings, except 7.5x7.5cm, 10x10cm and 15x15cm. Higginsons enema (rubber), Avoca Wart Treatment Set and the Aero Chamber have been deleted from the list, says PSNC.

New indication for Gemzar

Gemzar (gemcitabine) has had its licence extended to include locally advanced and metastatic pancreatic cancer.
Lilly Industries. Tel: 01256 315000.

Calcort distribution

Hoechst Marion Roussel has appointed Shire Pharmaceuticals as the exclusive distributor in the UK and Ireland for Calcort (deflazacort). The agreement is effective from May 1 for at least ten years. Shire will use its own sales and marketing operation.
Shire Pharmaceuticals Ltd. Tel: 01264 333455.

Cox cefaclor

Cox has launched its own generic cefaclor capsules 250mg in blister packs (NHS price 100, £43.32) and 500mg (50, £48.74).
Cox Pharmaceuticals Ltd. Tel: 01271 311200.

Ticar discontinued

Link Pharmaceuticals has discontinued Ticar (ticarcillin) in both 1g and 5g presentations because of difficulties in manufacture and supply. Existing stocks should be utilised as no credit will be given for returns.
Link Pharmaceuticals Ltd. Tel: 01403 272451.

Infanrix Hep B vaccine

Smithkline Beecham Biologicals' Infanrix Hep B vaccine has received positive opinion from the EMEA. A European licence is expected within the next few months. Infanrix Hep B is the first vaccine worldwide to combine hepatitis B with diphtheria, tetanus and acellular pertussis.

Temazepam oral

An oral temazepam solution (10mg/5ml x 300ml bottle) is available from Lagap from May 6, with a trade price of £9.95.
Lagap Pharmaceuticals. Tel: 01420 478301.

Alphagan treats glaucoma

Allergan has launched Alphagan eye drops, a second generation alpha-2 agonist for glaucoma which has minimal systemic effects.

Alphagan (brimonidine tartrate 0.2 per cent) reduces intraocular pressure (IOP) by decreasing the production of aqueous humour and increasing uvescleral outflow.

It is as effective as non-cardioselective beta-blockers (timolol) and more effective than cardioselective beta-blockers (betaxolol). It displays no clinically-significant effects on cardiovascular or lung function.

The drug is well tolerated and users report higher comfort rates when compared with betaxolol. This may help compliance.

Alphagan is indicated for the reduction of IOP in patients with open angle glaucoma or ocular hypertension, either as monotherapy in patients who cannot tolerate topical beta-blockers or as an adjunct to beta-blocker therapy where IOP has not been adequately controlled.

The dose is one drop to the affected eye(s) every 12 hours, but if other topical ophthalmic treatments are used, a 5-15 minute gap between each should be observed.

No dosage adjustment is needed for elderly patients. Safety and effectiveness in children and pregnancy has not been established.

Brimonidine is contra-indicated in patients on monoamine oxidase inhibitors or antidepressants affecting noradrenergic transmission such as tricyclics and mianserin.

Caution should be exercised in patients with severe cardiovascular disease, depression, cerebral or coronary insufficiency, Raynaud's syndrome and hepatic or renal impairment.

Additive or potentiating effects of brimonidine may be seen with CNS depressants. Caution is advised in patients on drugs affecting metabolism and uptake of amines; antihypertensives and/or cardiac glycosides; and systemic agents interacting with alpha-adrenergic agonists.

The most frequently reported ocular adverse events were ocular hyperaemia, burning/stinging, blurring, foreign body sensation, conjunctival follicles and ocular pruritis. The most frequently reported systemic effects were oral dryness, headache and fatigue/drowsiness.

Alphagan comes in 5ml dropper bottles (NHS price £10.80).
Allergan UK. Tel: 01494 444722.

Zofran launched in suppository form

Patients who have difficulty with the administration of oral or intravenous Zofran now have the option of using suppositories.

Each contains 16mg of the anti-emetic ondansetron, which is bio-equivalent and price-equivalent to two 8mg Zofran tablets. The dose is one suppository to be inserted one to two hours before treatment. It is not recommended for children.

Zofran Suppositories provide rapid control of chemotherapy-induced emesis and are of benefit to patients who find intravenous dosing traumatic or impractical, or who have swallowing difficulties. Chemotherapy can result in painful mouth ulcers, while radiotherapy can induce a sore throat and dry mouth.

Patients with very poor emetic control, who cannot hold down oral anti-emetics long enough for them to be absorbed, may also benefit from suppositories.

Zofran Suppositories come in outers of five (NHS price £81).
Glaxo Wellcome UK Ltd. Tel: 0181 990 9000.

MEDICAL MATTERS

Navelbine chemotherapeutic agent now in UK

Navelbine is a new chemotherapeutic agent for non-small cell cancer and advanced breast cancer which has been in use in France since 1989.

Navelbine (vinorelbine) is a semi-synthetic vinca alkaloid derived from the Madagascan Periwinkle. It kills cancer cells by disrupting the normal process of cell division – specifically the formation of mitotic microtubules.

Studies have shown vinorelbine to be relatively selective with low neurotoxicity compared to other vinca alkaloids.

Clinical side-effects are infrequent. Alopecia affects only 2.7 per cent of patients, constipation only 4 per cent, and there is a minimal incidence of nausea or vomiting, so that anti-emetics are not routinely required.

Navelbine (10mg/ 1ml or 50mg in 5ml) is given as an intravenous infusion.
Pierre Fabre Oncology. Tel: 01962 856956.

A potential cure for the common cold?

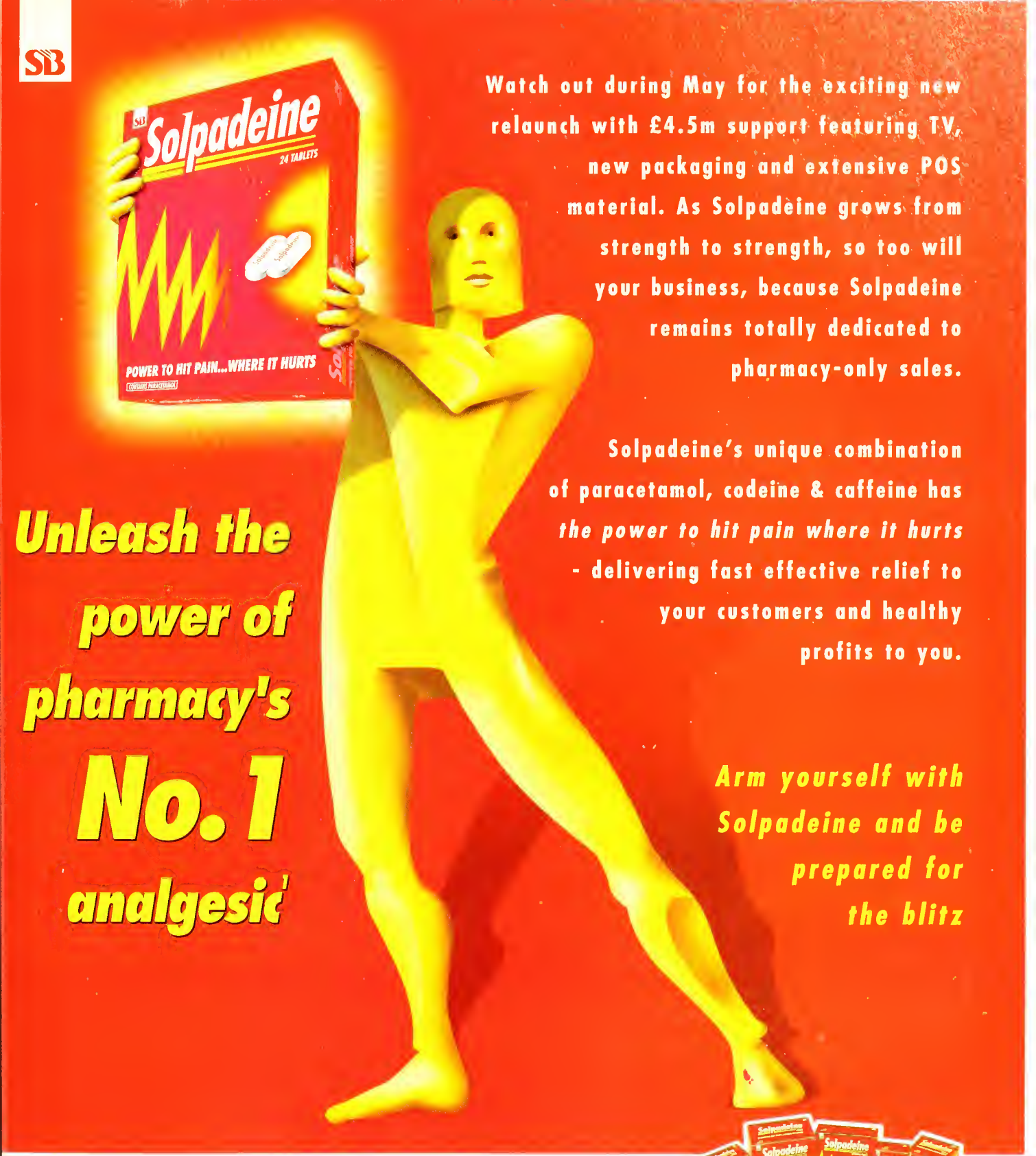
Boehringer Ingelheim is reporting research successes with a compound for preventing or reducing symptoms in 70 per cent of common colds.

Outlining BI's R&D last week in Frankfurt, vice chairman Professor Rolf Krebs said that the compound, 'soluble ICAM', is showing prophylactic and therapeutic properties in blocking rhinoviruses in 70 per cent of cases.

"I envisage in five or ten years this could be a product which could be used OTC," he said.

Development work on metered dose inhalers with alternative propellants is nearing completion. A pocket nebuliser, Respimat, is making "good progress".

Marketing authorisation is expected of pramipexole, a selective dopamine antagonist developed jointly with Upjohn for the treatment of Parkinson's disease. BI will also be submitting an application in Europe for nevirapine, the first non-nucleoside inhibitor of reverse transcriptase in HIV.



Watch out during May for the exciting new relaunch with £4.5m support featuring TV, new packaging and extensive POS material. As Solpadeine grows from strength to strength, so too will your business, because Solpadeine remains totally dedicated to pharmacy-only sales.

Solpadeine's unique combination of paracetamol, codeine & caffeine has *the power to hit pain where it hurts* - delivering fast effective relief to your customers and healthy profits to you.

Unleash the power of pharmacy's No. 1 analgesic[1]

Arm yourself with Solpadeine and be prepared for the blitz

Solpodeine Copsules, Solpodeine Soluble Tablets, Solpodeine Toblets Praduct Information
Presentotian: Each tablet, soluble tablet or capsule contains Paracetamol Ph Eur 500 mg, Codeine Phosphate Ph Eur 8 mg and Caffeine Ph Eur 30 mg **Uses:** Rheumatic pain, sciatica and lumbogo, period pain, toothache, neuralgia, migraine, headache, sinusitis and influenza **Dasoge ond administrotian:** *Adults and children 12 and over:* Two capsules/tablets up to four times daily **Controindicotians, warnings, etc. Controindicotions:** Hypersensitivity, conditions contraindicating opioids **Precoutions:** Severe renal or hepatic impairment, non-cirrhotic alcoholic liver disease, conditions exacerbated by opioids, prostatic hypertrophy and inflammatory or obstructive bowel disorders. Solpadeine soluble tablet contains 427 mg of sodium, caution with salt restricted diet **Interactions:** Metoclopramide, domperidone cholestyramine, coumarins (prolonged regulor daily use of paracetamol only), monoamine-oxidase inhibitors, CNS depressants (including alcohol) **Use in pregnoncy ond loctotion:** There is inadequate evidence for the safety of codeine in human pregnancy. Not contraindicated in breast feeding **Effects an ability to drive ond use mochines:** Patients should not drive or operate machinery if affected by drowsiness **Adverse reactions:** Paracetamol: Hypersensitivity including skin rash, reports of blood dyscrasias (not necessarily causally related). Codeine: constipation, nausea, vomiting, dizziness, light-headedness, confusion, drowsiness and urinary retention. Tolerance and dependency can occur, especially with prolonged high doses of codeine. High doses of caffeine may produce headache, tremor, nervousness and irritability **Overdose:** Liver damage is possible in adults, immediate medical referral is necessary.
Legal Cotegory: PCDI. **Retail price:** 12 capsules £1 90, 24 capsules £3 29, 72 capsules £6.75, 12 soluble £2 15, 24 soluble £3.55, 60 soluble £6 45, 12 tablets £1 90, 24 tablets £3 29, 60 tablets £6 15 **Product licence No:** Capsules: PL0071/0186, Soluble tablets: PL0071/5091, Tablets: PL0071/0396. Further information is available from the product licence holder SmithKline Beecham Consumer Healthcare, Brentford TW8 9BD, U.K. **Dote of preporatian:** March 1997. Solpodeine is a registered trade mark

SmithKline Beecham
Consumer Healthcare

SmithKline Beecham Consumer Healthcare, Brentford, TW8 9BD, U.K.

1 Nielsen Pharmacy 1996

COUNTERpoints

Sleepia eyes are drawn to blue capsules

Sleepia is a new diphenhydramine sleep aid which comes in the form of blue, liquid-filled, soft gel capsules.

Pfizer Consumer Healthcare, which is launching Sleepia in mid-May, believes the move away from the traditional 'little white tablet' will appeal to insomniacs worried about taking medication. Packs (eight capsules, $2.99) are flagged with the phrases 'non-habit-forming' and 'helps restore natural sleep' to allay concerns. Sleepia carries a Pharmacy licence.

The dose for adults and children over 16 years is one capsule (diphenhydramine hydrochloride 50mg) to be taken 20 minutes before bedtime for occasional sleeplessness. If sleep patterns are not restored within ten days, patients should be referred to their GP.

The launch is supported by a $1.5 million television advertising campaign, together with consumer leaflets, teaching aids for pharmacy and POS.

According to Pfizer Consumer Healthcare marketing manager Barbara Hodgson, gel capsules have driven the growth of sleep aids in the US, where the company already has a gel capsule sleep aid.

More than a third of adults are affected by insomnia, but only 10 per cent of them reach out for an over the counter remedy. The UK sleep aids market is worth $11m.

Pfizer Consumer Healthcare.
Tel: 01420 84801.

When hayfever gets up your nose

Congested hayfever sufferers are being targeted by a new $750,000 advertising campaign for Aller-eze Plus.

Appearing in national newspapers and weekend supplements, the colour ads will run regularly over the entire hayfever season.

A new range of POS is available. Aller-eze Plus (clemastine plus phenylpropanolamine) is for the treatment of congested hayfever.

● Aller-eze Clear, which contains terfenadine, has now been discontinued.

Novartis Consumer Healthcare.
Tel: 01306 742800.

Zovirax breaks with traditional ads

Zovirax Cold Sore Cream is hitting the national press in a bold new advertising campaign.

In a move away from traditional healthcare ads, they will be themed with the surrounding editorial content, ie taglines such as 'un-forgettable performance' in arts sections.

Part of a $3 million marketing investment, this campaign is being complemented by new colour advertising in women's magazines.

Wellcome Foundation Ltd.
Tel: 0181 990 9000.

Hard-hitting Migraleve campaign

Pfizer has opted for a hard-hitting advertising campaign for Migraleve to better convey the pain and agony that comes with migraine.

Tagged with 'A migraine is not just a headache – Migraleve is not just a headache pill', the visuals feature agonised, screaming faces.

The £1 million campaign aims to educate sufferers and non-sufferers about migraine, and the need for tailored medication from the pharmacy. Pfizer Consumer Healthcare marketing manager Barbara Hodgson says: "The images we have selected may shock some people, but migraine sufferers do not relate to adverts which they think trivialise the condition."

The campaign, starting in May and running through to the end of the year, will be carried in national newspapers, supplements and women's magazines.

Pfizer Consumer Healthcare.
Tel: 01420 84801.

Name those bugs!

Johnson & Johnson MSD is supporting its new-look Daktarin with a $2 million TV campaign, which will run from May 5 for four weeks.

The advertising highlights the product's dual-action formula. It can be used to treat both fungal and bacterial bugs present in athlete's foot.

Featuring innovative sketch drawings of the two bugs, the commercial has a voice-over by Lenny Henry.

To increase awareness, pharmacy assistants can win a $50 Marks & Spencer gift voucher if they come up with fun names for the bugs.

Johnson & Johnson MSD Consumer Pharmaceuticals.
Tel: 01494 450778.

Andrews adds extra fizz for headache/indigestion relief

Smithkline Beecham has introduced Andrews Seltzer Extra for the dual relief of indigestion and headache.

Each effervescent tablet (ten, $1.89) contains paracetamol 500mg, sodium bicarbonate 1,342mg and caffeine 65mg. The total sodium content of each tablet is 427mg. The product carries a GSL licence.

The launch is being supported by a $1.4 million television advertising campaign during the summer, the key purchasing period for the gastro-intestinal category, according to SB. POS is also available.

The packs have been designed to be merchandised horizontally or vertically for maximum shelf impact.

Smithkline Beecham Consumer Healthcare UK.
Tel: 0181 560 5151.

A whiter shade of pale

White eyelashes will be the new look for this summer, according to Miners International.

The company has introduced white variants of its Big Build Up and All Weather Mascaras ($1.99 each).

New, too, are white nail polish, lipstick, liquid eyeliner and eyeliner pencils. Retail prices range from $1.49 to $1.99.

Miners International Ltd.
Tel: 01264 350379.

Simple's new premium-quality line-up

Smith & Nephew has launched a new premium range for Simple skin care.

Simple Premium includes two new products – Anti-Wrinkle Cream ($5.99, 50ml) and Anti-UV Moisturising Lotion ($5.99, 100ml). Also in the range is Vitamin Enriched Day Cream ($4.99, 50ml), which is replacing and upgrading the existing Moisture Rich Replenishing Cream.

Designed to cater for specific skin care needs, the products are slightly higher in price than the rest of the Simple range.

Higher-performance products form part of a long-term strategy for the brand.

Smith & Nephew Consumer Products Ltd.
Tel: 0121 327 4750.

Palmer's stretches to cocoa butter

Cocoa Butter Formula Massage Cream for Stretch Marks is a new addition to Palmer's cocoa butter skin care range.

Formulated to help in the prevention of the appearance of stretch marks, the product contains pure cocoa butter, vitamin E, collagen and elastin.

The launch will be supported with advertising in parenting titles. Public relations activity will include reader sampling offers in both the parenting and women's interest titles.

A 125g tube of Cocoa Butter Formula Massage Cream retails at £4.99.

ET Browne UK Ltd.
Tel: 0181 554 7000.

New flexible friend for Pro-V

In a major launch for Pantene Pro-V, a hairspray line-up is being introduced by Procter & Gamble.

Incorporating a new hairspray fixative, called Elastesse, the range has been developed to provide flexible hold with a natural feel.

Elastesse is designed to form flexible bonds which can stretch and contract, allowing the style to move more freely yet bounce back. A built-in conditioner helps improve the shine and feel of the hair.

Pantene Pro-V Flexible Hold with Elastesse is available in three variants – Natural Hold, Extra Hold and Maximum Hold. Retail prices are $1.49 (75ml), $2.99 (250ml). Natural Hold and Extra Hold also come in non-aerosol versions ($2.99, 150ml).

The launch will be supported with an $8 million campaign over the next 12 months. This will include a heavyweight TV campaign, advertising in top teen and beauty magazines, and a national sampling initiative to around 5.6 million households.

Procter & Gamble (Health & Beauty Care) Ltd.
Tel: 01932 896000.

Alpha Silk is St Ives' latest Swiss smooth operator

Alpha Silk is a new body lotion in the St Ives Swiss Formula range.

It is formulated to gently smooth away rough, dry skin from the epidermal layer and replenish it with silk protein and collagen elastin.

A blend of fruit-derived acids, it contains herbs such as calendula, rosemary and aloe gel.

Retail price is $3.19 for a 300ml pump.

Alberto-Culver Co UK Ltd.
Tel: 01256 57222.

Astral Hydroplens advertising campaign is heaven-sent

Dendron is backing new Astral Hydroplens moisturisers for face, hands and body with advertising support this summer.

Running from May to September, a $550,000 woman's press campaign is aimed at the 15-24 age group. Colour advertisements will appear in *Cosmopolitan*, *Company*, *New Woman*, *Bliss* and *Clothes Show*.

The advertising builds on the theme 'for heavenly bodies, for the face of an angel forever', which has created a strong, modern image for Astral Original all-purpose moisturising cream.

PR activity will include giving away triple sachets of the new range to thousands of 15-24-year-olds at the popular *Cosmo* show in May.

Dendron Ltd.
Tel: 01923 229251.

Avent offers stimulating alternative with Isis

An innovative manual breast pump is being introduced into the Avent range in mid-June.

The new Isis model dispenses with springs and seals, and generates suction using a one-way valve and silicone diaphragm.

Key to its operation is a silicone massager cushion, which sits inside the funnel. As well as offering a better fit and seal with the breast, the cushion has five stimulators which massage the area behind the nipple when the unit is pumped, encouraging the 'let down' reflex.

The suction that can be generated is stronger than with the existing unit, and can be controlled during pumping so that milk is drawn into the collecting bottle at a comfortable pressure.

The Isis can be used in conjunction with both the existing reusable Avent feeding bottles and disposable bottle bags.

It will retail at £27.50, which includes a sealing lid, teat, two spare valves and two diaphragms.

The new pump is the first in a series of related items that the company is planning.

The manufacturer will be putting around £100,000 behind the new line in advertising and promotional support.

FSA puts the market for breast pumps and accessories at £2.7 million, with 70 per cent of sales coming from manual, as opposed to battery-operated, units. Cannon claims a market share of just over 55 per cent.

Cannon Rubber Ltd.
Tel: 01787 267000.

ON TV NEXT WEEK

Aquafresh Whitening: U

Bazuka: G, B, Y, TT

Colgate Sensation range: All areas

Daktarin: GTV, STV, B, G, Y, C, TT, C4, Satellite

Garnier Nutralia shower gel: All areas

Head & Shoulders: All areas

Hedex: U

Ibuleve: S, HTV, M, A, W, U, G

L'Oréal Elvive Revitalising shampoo: All areas

Otex: S, HTV, M, A, W, U, G

Pantene: All areas except GMTV

Pepcid AC: TT

Predictor home pregnancy test: C4, C5, Satellite

Regaine: G, C, A, M, LWT, C4

Rennie: All areas

Wash & Go: All areas

Wella Experience: C4

Wella Viva Colour: All areas

GTV Grampian, **B** Border, **BSkyB** British Sky Broadcasting, **C** Central, **CTV** Channel Islands, **LWT** London Weekend, **C4** Channel 4, **U** Ulster, **G** Granada, **A** Anglia, **CAR** Carlton, GMTV Breakfast Television, **STV** Scotland (central), **Y** Yorkshire, **HTV** Wales & West, **M** Meridian, **TT** Tyne Tees, **W** Westcountry

Putting feet first

June 1-7 is Foot Health Week, which is sponsored by the Foot Health Council. Prevention is better than cure is the keypoint of the campaign, which will be promoted through an intensive media campaign, including radio interviews.

Foot Health Council.
Tel: 0171 486 3381.

F1 phonecards have pole position

Gillette is promoting its razor blades with a phonecard giveaway throughout May.

Phonecards featuring action shots of the Benetton Formula 1 motor racing team are available free on packs of Gillette Contour Plus, Contour, GII Plus and GII razor blades.

All packs of five in the range contain a free £1 phonecard; packs of ten have a £2 card.

Gillette UK Ltd.
Tel: 0181 560 1234.

Wilkinson Swords' razor sharp offers

Wilkinson Sword is offering a free shaving gel with its Protector and FX Performer razors.

Special 75ml trial-size cans of Wilkinson Sword shaving gel are packaged with the razors.

Available for two months from May, the promotion is designed to provide added value, encouraging purchase and gaining trial of both the razor and the gel.

- **Wilkinson Sword is hoping to stimulate trial of its Lady Protector razor with a £1 off promotion during the months of May and June. Price-marked packs are available for the reduced rsp of £3.49.**

Wilkinson Sword Ltd.
Tel: 01670 713421.

Get plastered and win prizes

Coloplast is launching a Compeed Plasters summer window promotion.

Independent retailers are offered free point of sale material for display (available from mid-May) and a chance to win one of several prizes in a competition to find the most innovative window display. Prizes include passes giving one year's free entry to a local cinema.

The contest will be judged on photographs sent in by entrants, as well as by a team of 'mystery shoppers' who will secretly visit participating retailers throughout June.

Entrants must submit photographs by June 14.

Coloplast Ltd.
Tel: 01733 392000.

Persona package planned for independent pharmacies

Unipath is planning television advertising and an extensive training programme when the Persona contraceptive system is launched to independent pharmacies in October.

There will be training seminars at 42 venues in September, with two representatives per pharmacy invited to attend. Company sales staff will also give in-pharmacy presentations. The aim is for all stockists to be trained before the launch. Orders will be taken from the end of July for delivery in the week beginning September 22.

A wide range of POS will be available, with advertising kits for pharmacists to use in their local newspapers. The company is considering special incentives, such as advertising support, for those who have undergone training.

The starter pack, which includes a device to monitor hormonal changes and two packs of eight urine test sticks, will cost £49.45. A monthly supply of test sticks will retail at £9.95.

The company says it has learnt from mistakes made during the exclusive launch to Boots and intends to show a firm commitment to independents.

Unipath Ltd.
Tel: 01234 835000.

Kodak Processing extends instant relief to UniChem

Good news! Kodak Processing is extending its Film Inclusive service for UniChem Photo Service Retailers.

"The best offer that Kodak Processing and UniChem have come up with. It's simple to understand and operate, and it increased sales."

"The offer has increased our sales by threefold."

These are just some of the reactions we have received from satisfied UniChem Photo Service Retailers who have taken up the Kodak Processing Film Inclusive service and seen an impact on their sales. Research into the service shows that over 90 per cent of UniChem customers who have used the service wanted it to continue, and 75 per cent would recommend it to other UniChem retailers.

This service is exclusive to UniChem Photo Service Retailers in the pharmacy sector, and offers a **Kodacolour** 200 film with 4in/10cm prints.

Your customers will receive the **Kodacolour** 200 film in a bag together with their prints in a Prints by Kodak wallet. The service is available on 35mm colour print film only.

Competitive edge

This powerful offer has been designed to give you a strong competitive edge over local competition. It's also a great tool for attracting new customers, as well as driving your profitability. It's simple – your customers receive a film returned with their prints.

Whatever the volume or exposure length of film processed, you will receive a fixed margin of 30 per cent.

Not only that, now, with the extension of the service, you can capture those sales of the all-important D&P summer peak.

The service will appeal to your customers. It's convenient – they just need to make one purchase for D&P and a branded film. It's excellent value – £4.99 rrp 1-28 and £5.99 rrp 29-39 prints, and, moreover, the consumer gets the quality assurance of a **Kodak** branded film and Kodak Processing D&P service.

Kodak Processing will supply you with a free point of sale pack to help you get started, which comprises a colourful 'A' board overlay, A3 window vinyl and A4 counter insert, as well as clear instructions on how to operate the service.

Increased sales

This is just one of the range of services offered by the UniChem Photo Service and Kodak Processing to help increase your sales. So switch to the Film Inclusive service – it's a great tonic for your D&P sales.

If you would like to hear more about the Film Inclusive service, contact Chris Tully at Kodak Processing on 01442 844573.

Kodak Processing

UniChem

Delivering Healthcare

Getting down to show business

CHEMEX'97
21 - 22 SEPTEMBER 1997
OLYMPIA 2 LONDON

With its new educational benefits, Chemex 97 promises to be better than ever.

Professional development will be a keypoint. Indeed, this theme is being expanded upon year after year at the UK's leading exhibition for pharmacists. Looking ahead to September 21-22, London's Olympia will be the venue for a series of business seminars and a model shop will provide free expert advice on ways to achieve retail success.

Giving pharmacists the chance to mix business with pleasure, the show will enter all its pre-registered visitors into a prize draw for a £1,000 holiday voucher. To help them get the most from their trip to London, discounted, high-quality hotel packages in central London are available (further details in *C&D* June 7).

Over 130 exhibitors will be contributing discounts and special offers to a voucher book, which is free to all those attending. This valuable book allows people to enter prize draws, receive substantial discounts on orders and take home a wide variety of product samples.

Visitors with children will have the opportunity to leave their offspring in a registered creche.

The Chemex team: (front row l-r) Simon Proctor, sales manager; Liz Bokaie, marketing manager; (back row l-r) Nicki Varley, event co-ordinator; Andy Gibb, event director; Jessica Lonnkvist, sales executive;and Kristie Dennis, PR manager

A showcase for leading pharmaceutical products, Chemex 97 has the endorsement of key organisations like the National Pharmaceutical Association and the Royal Pharmaceutical Society. "Over the years, Chemex has been the regular event which pharmacists rely on as an ideal way to keep abreast of trends in pharmacy business and practice," says NPA's Trefor Williams.

Business is likely to be brisk at this year's exhibition. Over 65 companies have already given confirmed that they will be exhibiting. Top names ranging from Crookes Healthcare, Norton Healthcare, APS Berk, Boehringer Mannheim, Ethical Generics, Becton Dickinson and Doncaster Pharmaceuticals to Hadley Hutt Computing and Photo Me International will all be there.

"Chemex 97 is a key opportunity to meet with our existing and potential clients," says John Beighton, sales and marketing manager of APS Berk. "We have enjoyed a successful participation in the past and are confident that 1997 will be equally, if not more, rewarding."

Simon Proctor, sales manager for Chemex, comments: "We're delighted with the level of interest shown by the new exhibitors and the companies which have participated in Chemex in the past. Everyone is particularly enthusiastic about the new educational benefits."

Exhibitors are being provided with a detailed marketing and publicity guide to assist in creating awareness before, during and after the event. The exhibition organisers will also help exhibitors with the planning and implementation of their promotional ideas for the event.

For more information about Chemex contact Simon Proctor on 0181 987 7706 or Jessica Lonnkvist on 0181 987 7708.

Visitors can pre-register for tickets by calling 0181 987 7620.

Victor Kiam within earshot!

Entrepreneur Victor Kiam is jetting into London for Chemex to promote his travel companies, Travel Smart and Cirrus Air Technologies. In particular, he will be attracting interest in his new Earplanes product, which is aimed at air travellers who experience ear pain because of sinus conditions, allergies or colds, or who have ears sensitive to air pressure changes.

Famous as the man who 'bought a Remington shaver and liked it so much he bought the company', Mr Kiam is now setting his sights on revolutionising travel and personal care products.

REGISTRATION FORM (COMPLETE CLEARLY IN BLOCK CAPITALS)

Fill in your name (as you wish it to appear on the CiCPM.)

Forename .....
(all other initials as registered with the RPSGB or PSNI) .....

Surname .....

Registration No: RPSGB.....

PSNI: .....

Pharmacy address.....

.....

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County..... Postcode .....

Tel no.....

Fax number .....

E Mail.....

I enclose a cheque to Miller Freeman:

CICPM part 1 £117.50 (inc VAT) .... (£ .)

CICPM part 2 £235.00 (inc VAT) .... (£ .)

CICPM parts 1&2 £323.13 (inc VAT) (£ .)

Total . ..... (£ .)

Send cheques and forms to Sue Cheeseman/Claire Newman, Miller Freeman, Pharmacy Group Special Projects, Sovereign Way, Tonbridge, Kent TN9 1RW (tel 01732 364422).

Additional single module copies at £4.00 per module (plus VAT of £0.60), will be available only to Chemist & Druggist subscribers or registered Community Pharmacy readers from Miller Freeman (Full set £40.00 plus VAT of £5.96).

SB PharmAssist
Pharmacy Training Programme

All you and your business needs - The Certificate in Community Pharmacy Management...

...produced in association with The School of Pharmacy, The Queen's University of Belfast, from Chemist & Druggist and Community Pharmacy, supported by Smithkline Beecham Consumer Healthcare (PharmAssist)

How to register

The ten modules for the first half of the course will come free to UK pharmacies through either Chemist & Druggist or Community Pharmacy (see insert with this module in this issue for full details).

Pharmacists aiming to complete CiCPM must register with Miller Freeman and pay a fee of £100 to cover the first half of the course. (Registrants must subscribe to C&D or be on Community Pharmacy's mailing list.) The ten modules provide 50 hours of learning, or half the 100 hours needed for the CiCPM. The fee covers project administration, registration and telephone marking, and three progress reports.

Pharmacists who wish to proceed to second 50-hour project stage must have registered with Miller Freeman for the module component.The second stage attracts a fee of £200 to cover course preparation, marking, access to a course tutor and certification by QUB. Pharmacists registering for both parts simultaneously can save £25.

£2M PRESS, POSTER AND REGIONAL TV CAMPAIGN

Back to normal

Gets hayfever sufferers

Sufferers can't buy a faster, more effective treatment. Clarityn Allergy's threefold action[1,2,3] relieves the eye, nose and throat symptoms of hayfever within minutes.[4] What's more, Clarityn Allergy won't make them drowsy[5] or interact with alcohol.[6]

Even more important is the fact that you can't recommend a safer antihistamine. Clarityn Allergy does not have the cardiotoxicity associated with terfenadine or astemizole,[7] and can be recommended with confidence.[8]

With this reassuring safety profile, it'll come as no surprise that Clarityn Allergy Syrup is now available OTC for children as young as two years old.

NEW

***Clarityn Allergy* – you can't recommend a safer antihistamine**

Abbreviated product information

Clarityn Allergy Clarityn Allergy tablets contain 10mg loratadine. Clarityn Allergy Syrup contains 5mg loratadine per 5ml. *Indications:* For the relief of symptoms associated with hayfever, perennial allergic rhinitis and idiopathic chronic urticaria. *Children aged 2 to 12 years:* For the symptomatic treatment of hayfever and allergic skin conditions such as urticaria. *Dosage:* Adults and children aged 12 and over: one tablet once daily or two 5ml spoons of syrup once daily. *Children aged 2 to 12 years:* Bodyweight < 30kg – one 5ml spoon of syrup once daily. Bodyweight > 30kg – two 5ml spoons of syrup once daily. *Contra-indications, precautions:* Hypersensitivity, pregnancy and lactation. Use in children under 2 years. *Side effects:* Rarely, fatigue, nausea and headache, alopecia, anaphylaxis, abnormal hepatic function, supraventricular tachyarrhythmias. Tachycardia and syncope have also been reported rarely although causal relationship has not been established. Concomitant administration of drugs which inhibit P450 3A4 and 2D6 metabolic pathways may result in elevated plasma levels of loratadine or the concomitant medication. *Pack size:* Cartons of 7 tablets. Bottles of 50ml Syrup. *Retail price:* Tablets £4.25; Syrup £6.99. *Legal category:* P. *Product licence number:* Tablets 0201/0175; Syrup 0201/0173. *Product licence holder:* Schering-Plough Ltd., Shire Park, Welwyn Garden City AL7 1TW. *Date of revision:* January 1997.

References 1. Barnett A. *et al.*, Agents Actions, 1984; **14**: 590-597. 2. Staquet M.J. *et al.*, Amer. Acad. All. Immunol., 1995; in press: Abstract. 3. Dugas B. *et al.*, J. All. Clin. Immunol., 1994; **93**: Abstract. 4. Soto Roman L. Today's Ther. Trends 1988; **6**: 19-27. 5. Betts T. *et al.*, Proc. XIII Int. Congr. Allergol., and Clin. Immunol., Montreux 1988; 74-79. 6. Moser L., *et al.*, Eur. Acad. of Allerol. and Clin. Immunol., Budapest, May 1986; Abstract. 7. Botstein P., Am. J. Cardiol. 1993; 72: 50B-Z. 8. Haria *et al.*, Drugs 1994; **48(4)**: 617-637.

SCHERING-PLOUGH CONSUMER HEALTH

We're conf

£2 million

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drive sales

Diflucan One is going down even better right now.

Capturing over a third of the OTC vaginal thrush sector, it is clearly the brand leader in £ sales in a market that has doubled in size[1] since Diflucan One launched in November 1995.

To make sure sales keep going strong, we're stepping up the ad spend to £2 million in 1997 on TV and Press.

Compelling advertising that will tell thrush sufferers everywhere what they want to hear.

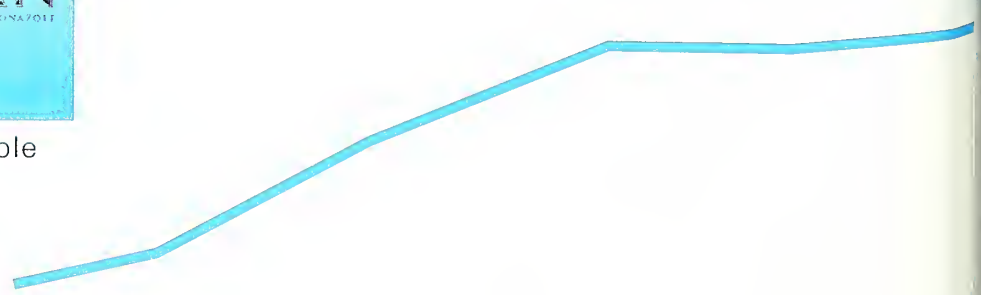
That Diflucan One is convenience itself: one pill, swallowed with a glass of water, is the complete course.

And that Diflucan One works. On average, women experience relief from thrush symptoms in one day and complete relief after just two days[2].

Everything points to the fact that while we're busy driving sales down, you'll be busy piling profits up.

JUST THE ONE FOR TREATING THRUSH

Contains fluconazole



Nov 95
launch

1 IRI Infoscan, 29 December 1996. 2. Report of an International Multicentre Trial (1989) Brit J Obstet. Gynaecol 96. 226-232. **Abbreviated product informa for Diflucan One (fluconazole).** *Presentation.* Capsule containing 150mg fluconazole. *Indication and dosage.* Vaginal candidiasis. Adults (16-60 years): single 150mg dose. *Contra-indications.* Hypersensitivity to fluconazole or related azoles, pregnancy and women of childbearing potential unless adequate contrace

ent
advertising
to
own.

Warnings Lactation: Not recommended. *Drug interactions* Anticoagulants, cyclosporin, oral methotrexate, phenytoin, sulfonylureas and thiazides. Nausea, abdominal discomfort, diarrhoea, flatulence and rarely anaphylaxis. *Legal category* [illegible]. *Package quantity and* [illegible]. PL1906/0017). *Product Licence Holder* Pfizer Consumer Healthcare, Wilson Road, Alton, Hampshire GU34 [illegible]. Date of preparation: January [illegible]. UK.

Pfizer Consumer Healthcare

NPA to look into intimidation in-store

The National Pharmaceutical Association is to survey its members to discover the extent to which pharmacists are subjected to aggressive behaviour and intimidation from the public within the pharmacy.

Until information on the scale and nature of the problem is available, it is difficult to take action in support of members, says the Association. A questionnaire will be issued shortly in the NPA's Supplement.

If the problem is shown to be widespread, the NPA feels that much could be done in the areas of training, security advice and local networking to support pharmacists.

Because doctors face similar problems, the British Medical Association and the Royal College of General Practitioners are to be approached to collaborate on project work in this area.

Patient pack dispensing The NPA has made an appeal to the Medicines Control Agency to address issues arising from the patient pack initiative.

The Association supports PPD, but is concerned at the effect it will have on businesses unless issues such as residual stock, shelf space, confusion over special containers, prescription quantities and the provision of leaflets when medicines were supplied in odd quantities are resolved.

The Department of Health has been asked to clarify suggestions that patient packs will not create additional burdens on business.

The NPA's response to the recent MCA consultation paper includes its own assessment of the costs, and photographic evidence of shelf space problems.

Practice Resource Systems The NPA is still advising members against entering into any agreement on electronic transfer of prescriptions until the concerns of the NHS Executive, and medical and pharmaceutical professions, have been addressed.

Press reports suggest some multiples are on the verge of signing up to PRS, says the NPA, and this gives the impression that all outstanding concerns have been resolved. "This might panic independent pharmacists into signing up to the system."

The Association says it is still talking to other stakeholders to ensure that the electronic transfer of prescriptions is achieved in a managed way which allows all pharmacies to participate.

Manpower The NPA is still concerned about the manpower crisis in community pharmacy and is considering further research.

There is now a consensus that a manpower shortage does exist. The question is not so much 'if' there is a shortage, but 'why', considering the year on year increase in new registrants.

> If intimidation is widespread, much could be done to advise and support pharmacists

Talking directly to multiple and independent members about their recruitment experiences will, the NPA thinks, give direction to future research. It may also throw up possible solutions.

Drug misuse The NPA has responded to proposals from the DoH to update the clinical guidelines on the management of drug misuse and dependence.

New guidelines should reflect the increasing role of pharmacists, including supervised administration and syringe/needle exchange. They should also cover how an instalment prescription should be written.

The NPA is urging the DoH to distribute the guidelines to all pharmacies, as well as GPs.

Mental health services The NPA has welcomed the NHSE's Green Paper on 'Developing Partnerships in Mental Health', which it sees as an opportunity to develop a clearer framework for the management of services for the mentally ill.

The NPA is stressing that pharmacy services, which have developed beyond the dispensing of medicines, must be considered in any review of the delivery of care. Also, any assessment of training needs must include pharmacists.

The NPA favours the establishment of a joint health/local authority body to manage mental health in the community. 'Joint ownership' of the service, with a joint budget, would help solve the problem of funding medication management which falls between health and social care responsibilities, the NPA feels.

PHARMACY update

Hey, hey, hey, it's hayfever

The hayfever season has arrived earlier than expected thanks to a surprisingly warm spring. Derek Balon, community pharmacist and King's College lecturer, shows how pharmacists can prepare for the early callers

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 51), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JUNE 14, PROVIDES 1 HOUR OF CONTINUING EDUCATION

OBJECTIVES

- To differentiate between seasonal and perennial allergic rhinitis.
- To diagnose the conditions using the mnemonic SCRUTINY.
- To manage the conditions using the CARE criteria.
- To be aware of the drugs available for hayfever.
- To be aware of triggers.

Hayfever, or seasonal allergic rhinitis, although clinically minor is very unpleasant for the sufferer. However, the term 'hayfever' is a misnomer because its cause is not restricted to hay and fever is only rarely present.

The main symptom is rhinitis (inflammation of the nose) which occurs when an allergen enters the body and causes the release of vasoactive substances such as histamine. The allergen is an airborne protein commonly from plants, hence the seasonal peaks.

A second condition, perennial allergic rhinitis, is also caused by airborne protein but does not demonstrate seasonality and can occur at any time. The pathology is identical; only the causative agent differs.

Rare cases of allergic rhinitis are reported where the provoking factor is a chemical.

Incidence

Hayfever is a well recognised condition: 10 per cent of the public reported having suffered from it in the past year. It is more difficult to quantify perennial allergic rhinitis, but another 7 per cent self-reported such allergies.

It is rarely seen in infants or children under two, suggesting that sensitisation occurs over a number of years before overt clinical symptoms present. Various incidence figures are quoted: 30 per cent of sufferers develop the allergy by the age of ten, 60 per cent by the age of 30, with sensitivity diminishing with age.

Pathophysiology

The pathophysiology of allergic rhinitis involves the complex immune response (Type I) based on the disruption of mast cells. The mast cells involved are found near the small blood vessels and nerves, and in the connective tissue, skin, lymphoid tissue and respiratory epithelium.

Allergens which have penetrated the nasal and optic mucus membranes trigger the production of antigen-specific immunoglobulin (IgE). This binds to receptors on mast cells which are then sensitised.

Subsequent exposure to the antigen results in degranulation of the mast cell and release of various inflammatory and irritant mediators into the tissues, including histamine,

Continued on PII ▶

Box 1: seasonal allergen sources

Pollen	grasses, trees (birch, plane), flowers (chrysanthemum), wind-pollinated plants (cf insect pollination), weeds, rarely conifers	spring to autumn especially late May to mid-July. Later in the north

Box 2: perennial allergen sources

- Moulds and fungi
- House dust mite
- Feathers
- Cats, dogs, horses, etc
- Materials, eg mattress fillers, pillows, duvets
- Insect-derived and other detritus (eg in air-conditioning ducts)

Box 3: nasal and eye reactions characteristic of hayfever

Nasal reactions:

- excessive mucus production which is watery in nature
- nasal congestion and/or obstruction (swelling of membrane)

Eye reactions:

- lacrimation and periorbital swelling
- vasodilatation of conjunctival vessels (red eye)
- itch in eye (needle-like)

◀ *Continued from PI*

leukotrienes, prostaglandins, SRS-A, histamine, bradykinin and thromboxanes. These substances cause immediate reactions which include rhinorrhoea, capillary dilatation, oedema, itch and sneezing. About 50 per cent of patients with allergic rhinitis suffer from a recurrence of the symptoms some hours later, without any new allergen being present.

In longstanding cases, nasal mucosal thickening, loss of epithelial cilia and polyp development occur.

Patient presentation

Hayfever patients, including first-time sufferers, usually recognise their condition. The seasonality of hayfever is a simple clue to the problem, but this does not apply to the perennial sufferer. Their symptoms, which resemble a cold and can occur at any time of the year, including the peak periods of coryza, may not be immediately linked to allergens.

Questions to ask:

- what are the major symptoms?
- have you had this problem before?
- what makes it worse (taking account of the season)?
- do you or any member of your family suffer from hayfever, asthma or eczema?
- do you have a sore throat?

Diagnosis

Symptom complex

One of the first symptoms is episodic sneezing. This is followed by nasal and eye reactions (see Box 3) and may include ear and sinus involvement.

Sinusitis is associated with nasal congestion and is frequently found in chronic sufferers. Temporary loss of hearing with echo effects (blocked Eustachian tube) are reported.

Pyrexia, sore throat and malaise are absent. This clearly distinguishes hayfever from the potentially similar symptom presentation of coryza and flu.

Region

The major areas affected are the nose and eyes. The ears are rarely involved, but severe nasal congestion may occasionally spread to the Eustachian tube.

Universal factors

Patients who are prone to allergies are more liable to suffer with allergic rhinitis. This has a genetic component: there is a 30 per cent risk if one parent has atopic disease which increases to 50 per cent if both suffer. Nineteen per cent of children with allergic rhinitis also suffer from asthma, this occurs more in perennial sufferers than annual sufferers.

Provoking factors

The identification of potential allergens is one of the most important diagnostic pointers.

When considering seasonal allergic rhinitis, particular attention should be given to pollen. The following factors should be borne in mind.

1 The time of year for specific antigens (grasses, flowers, trees).

2 Location in terms of region and latitude – the flowering season is earlier in the south compared to the north; species of flowers and trees vary from country to country.

3 Time of day – pollen has the greatest concentration at ground level in early morning and later afternoon (because of prevailing air currents).

In perennial allergic rhinitis, the location of the attack may point to the allergen, eg an attack at a friend's home where there is a dog may be significant.

Relieving factors

Relief is obtained by avoiding the allergen.

Time/intensity

The severity and duration of the attack is related to the presence of the allergen and its concentration. The higher the pollen count, the higher both the incidence and severity of attacks. Similarly, close involvement with an allergenic source will increase both features for perennial sufferers.

Natural history

Seasonal and perennial forms are both episodic, relating to presence of the allergen.

Your current medication

There is little of significance in current drug usage. Some drugs of abuse may cause rhinitis.

Management

Management includes avoiding the allergen, protecting the mast cells or reducing the effects of the chemical mediators.

There are many drugs available to reduce the symptoms, but care must be taken to avoid interaction with a patient's current medication.

Chronic/risk group/age

Asthmatics are a group prone to rhinitis. It should be noted that pollen grains (10-100 millimicrons) are filtered by the nose and does not reach the lungs, so pulmonary effects are not usually a problem. However, wheezing or tightness of the chest requires immediate referral.

Patients with cardiovascular problems should be referred because of the added stress and contra-indications for some drugs.

Allergies

Allergies to drugs used to treat hayfever are rare.

Reaction of proposed medication

All antihistamines can cause drowsiness to some extent, but the newer ones are less likely to do so. Hazardous interactions are in Box 4.

Establish patient preference

Allergic rhinitis products are primarily designed to reduce the symptoms of rhinorrhoea and stinging, watery eyes. Nasal products are either topical or systemic. The systemic preparations produce effects at many sites and this must be taken into consideration. Patients whose sleep is disturbed by hayfever may prefer drowsy formulations. Some patients prefer local drops or sprays for nasal problems, but remember that systemic effects may occur.

Non-drug approach

While drug management is probably a necessary choice for seasonal allergic rhinitis, allergen avoidance is a worthwhile adjunct for the perennial form.

If the allergen is known to the 'perennial' sufferer, they should adopt avoidance procedures. Changing the type of bed linen; using a mattress cover, vacuuming house dust or avoiding pets are all suitable measures.

Seasonal allergic rhinitis patients should also avoid allergens. Keeping indoors during high pollen count days is ideal, but impractical. Patients should be reminded that the pollen concentration is highest in the morning and evening. They should close windows and avoid the countryside and mown grass.

Product selection

There are three major classes of drugs used to control the symptoms of allergic rhinitis: antihistamines, mast cell protectants and topical anti-inflammatory agents.

Continued on PIV ▶

Box 4: some systemic antihistamines used in allergic rhinitis

Drug	Used for allergic rhinitis	Notes
Sedative		
Chlorpheniramine	++	Also good for skin allergies
Brompheniramine	++	
Clemastine	++	
Diphenhydramine	-	Antussive activity
Phenindamine	+	
Promthazine	+/-	Sedation a useful side action
Trimeprazine	+	POM
Non-sedative		
Astemizole	++	Caution: interactions
Cetirizine	++	
Loratidine	++	
Terfenadine	++	Caution: interactions

OMIG'
nsult Summary of Product aracteristics before prescribing. ecial reporting to the CSM quired.
e Acute treatment of migraine with without aura.
esentation Tablets containing 2.5mg zolmitriptan.
sage and Administration The ommended dose of 'Zomig' to treat igraine attack is 2.5mg.
ymptoms persist or return within hours, a second dose has been wn to be effective. If a second dose equired, it should not be taken within ours of the initial dose.
satisfactory relief is not achieved, sequent attacks can be treated with g doses.
patients who respond, significant cacy is apparent within 1 hour of ing.
the event of recurrent attacks, it is ommended that the total intake of mig' in a 24 hour period should not eed 15mg.
mig' is not indicated for prophylaxis migraine.
ety and efficacy of 'Zomig' in diatrics, adults over the age of 65 patients with hepatic impairment e yet to be established.
ntra-indications Hypersensitivity any component of 'Zomig' and ontrolled hypertension.
cautions A clear diagnosis of graine must be established. Care uld be taken to exclude other entially serious neurological ditions. No data in hemiplegic or ilar migraine.
mig' should not be given to patients h Wolff-Parkinson-White syndrome arrhythmias associated with other diac accessory conduction pathways. mig' is not recommended in patients h ischaemic heart disease. In patients whom unrecognised coronary artery ease is likely, cardiovascular luation prior to commencement of atment is recommended.
with other $5HT_{1D}$ agonists, atypical sations over the precordium have n reported after administration of mig,' but in clinical trials these have been associated with arrhythmias ischaemic changes on ECG. 'Zomig' cause mild transient increases in od pressure.
ients should leave at least 6 hours ween taking an ergotamine paration and starting 'Zomig' and e versa. Concomitant administration other $5HT_{1D}$ agonists within 12 hours Zomig' treatment should be avoided. maximum intake of 7.5mg of 'Zomig' in hours is recommended in patients ing a MAO-A inhibitor. Caution in gnancy and breast-feeding. Use is ikely to result in an impairment of the ity to drive or operate machinery. wever, somnolence may occur.
desirable Effects Nausea, dizziness, nnolence, warm sensation, asthenia d dry mouth have been the most mmonly reported.
normalities or disturbances of sation have been reported; heaviness, tness or pressure may occur in the oat, neck, limbs and chest (no evidence ischaemic ECG changes), as may algia, muscle weakness, paraesthesia, aesthesia.
gal Category POM.
oduct Licence Number 12619/0116.
sic NHS Cost 3 tablet pack (2.5mg) 2.00. 6 tablet pack (2.5mg) with let £24.00.
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ther information is available from: NECA Pharma, King's Court, Water ne, Wilmslow, Cheshire SK9 5AZ.

7590/K Issued March 1997

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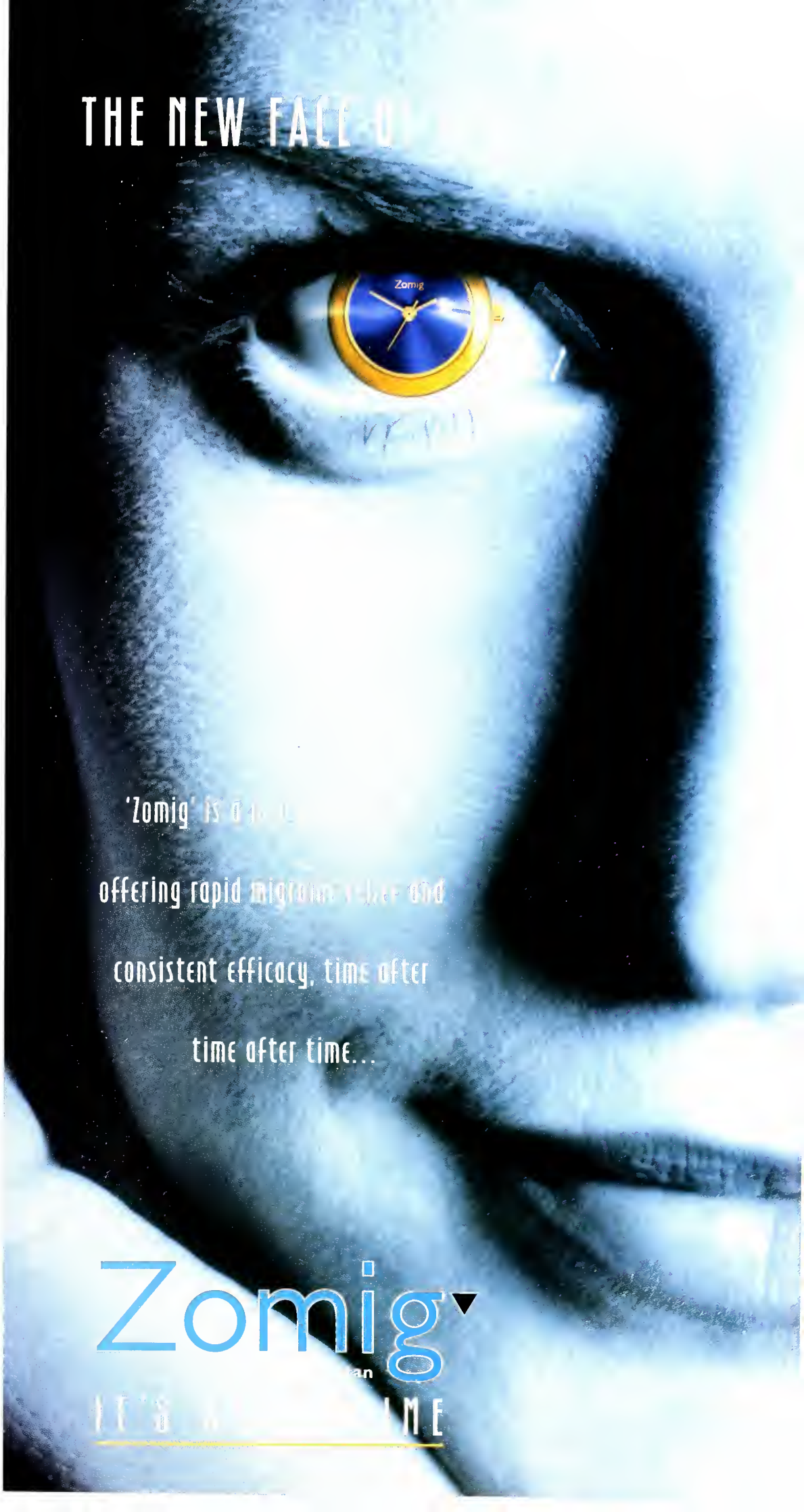

Box 5: hazardous interaction of OTC allergic rhinitis drugs with other medicines*

All antihistamines	Antidepressants, eg MAOIs, tricyclics
Astemizole Terfenadine	Anti-arrhythmics, eg amiodarone, disopyramide quinidine Antibacterials (some), eg erythromycin, 4-quinolones, clarithromycin and other macrolides[1] Antifungals (some), eg itraconazole, ketoconazole (systemic)[1] Other antihistamines Antipsychotics, eg chlorpromazine, haloperidol, pimozide Sotalol and perhaps other beta-blockers Diuretics (if the patient becomes hypokalaemic)

[1] also applies to Loratidine
* not all-inclusive list: see *BNF*

◀ *Continued from PII*

● **Antihistamines**
These are probably the first-line agents for systemic use. Primarily they act by competing with histamine for histamine receptors (see pathophysiology). Histamine is not the only substance which mediates the symptoms of the condition and thus, although the sneezing and itch may be reduced, other symptoms, including nasal decongestion, may still be apparent.

There are many drugs available: the *British National Formulary* lists at least 25 drug entities. There are also many different chemical classifications, but in practice it is sufficient to look at two.
1 First generation drugs, which have pronounced sedative effects.
2 Second generation, which are more H1 specific and therefore are less sedating (less antimuscarinic and centrally active). It must be emphasised that all currently available antihistamines carry some sedative effects, they only vary in the degree of sedation.

Table IV shows some of the systemic drugs available. Drug selection depends upon the patients requirements (sedation versus non-sedation), consideration of potential side actions and the rapidity of onset of action and its duration.

● **Mast cell protectants**
Sodium cromoglycate and nedocromil are the only two mast cell protectants currently available.

They act by reducing the breakdown of the mast cell and thus reduce the release of the mediators. They have to be administered prior to allergen exposure and should be used as a prophylactic rather than for a therapeutic effect. Their use should be continued while in contact with the allergen even if there are no clinical symptoms.

Sodium cromoglycate is available for use in the nose or eyes. It is combined with a topical nasal decongestant to provide patients with both prophylactic and therapeutic activity in one preparation.

● **Topical anti-inflammatory agents**
Corticosteroids inhibit release of the allergic mediators from mast cells, suppress the mediator response, reduce oedema and reduce migration of eosinophils and neurophils to the nasal mucosa. All these effects reduce the symptoms of allergic rhinitis.

Topical nasal corticosteroids are available over the counter. They are slow-acting and exert a prophylactic as well as therapeutic effect and therefore treatment should be started prior to potential attack. Patients should be cautioned about overuse as some absorption does occur at high dose levels. Epistaxis and local irritation are potential side-effects. When severe nasal congestion is present, instilled cortico-steroids may not penetrate to the nasal mucosa.

● **Decongestants**
The drugs mentioned above attempt to prevent or reduce the effects of allergic mediators. Decongestants are used to suppress or relieve the symptoms of allergic rhinitis after the mediator has been released and interacted with its target tissue. They are the same agents as those used for nasal relief of a cold (see 'Cold' articles in **Pharmacy Update** October 5 and November 2, 1996).

● **Topical sympathomimetics**
The metazolines, ephedrine, phenylephrine act locally by vasoconstriction, reducing blood flow and thus secretions. They are absorbed systemically, but the blood:drug level is normally sufficiently low to preclude serious patient/drug interaction. Thus they should be used with caution by the mildly-hypertensive and orally-controlled diabetic. They are contra-indicated in patients concurrently taking monoamine oxidase inhibitors.

Continual usage (more than five to seven consecutive days) may produce rebound congestion. Dosing frequency with the longer-acting metazolines is twice or three times a day, while the shorter-acting ones require three to four applications daily. Sprays are preferred to drops in adults, as the force required for administration results in better penetration of the drug.

● **Systemic sympathomimetics**
Pseudoephedrine, phenylpropanolamine, ephedrine and phenylephrine may be of value in some allergic rhinitis cases, but should be restricted to patients who have severe nasal congestion since they have significant side-effects. Drug management strategies listed above are preferred.

Their vasoconstrictor property results in decreased blood flow to the mucus membranes and thus reduced secretion in the nasal passages. This property also has a direct effect on blood pressure making them unsuitable for hypertensive patients. Pseudoephedrine has been shown to have little effect on normotensive patients, while ephedrine has the most marked pressor activity. They all have a direct effect on metabolism and should not be taken by diabetics or those with thyroid problems.

Terfenadine warning

Acting on the advice of the Committee on Safety of Medicines, the Medicines Control Agency is currently in consultation to reverse terfenadine to a Prescription Only Medicine. However, the MCA insists that terfenadine at the maximum adult daily dose of 120mg is safe but may result in serious or even fatal cardiac arrhythmias in patients with cardiac or hepatic disease.
Terfenadine also interacts with:
- grapefruit juice (psoralens)
- ketoconazole
- itraconazole
- erythromycin
- clarithomycin
- related imidazole anti-fungals and macrolide antibiotics.

Although there is insufficient evidence to justify a similar change to astemizole, the drug is being kept under close review.

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ACTION PLAN

1 List the hayfever preparations that you stock, together with their active ingredients, dose, onset and duration of action, interactions and special warnings. Note whether they cause sedation.
2 For the next 20 hayfever patients note symptoms, preparations previously used and your recommendations.
3 List the products appropriate for hayfever of the eyes. Note differences between them and brief your assistants.
4 Change your protocol for the sale of systemic antihistamines to take into account the precautions for terfenadine.

PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the June 14 issue, which will cover this week's College of Pharmacy Practice-accredited modules, together with those appearing in the May 17 issue.

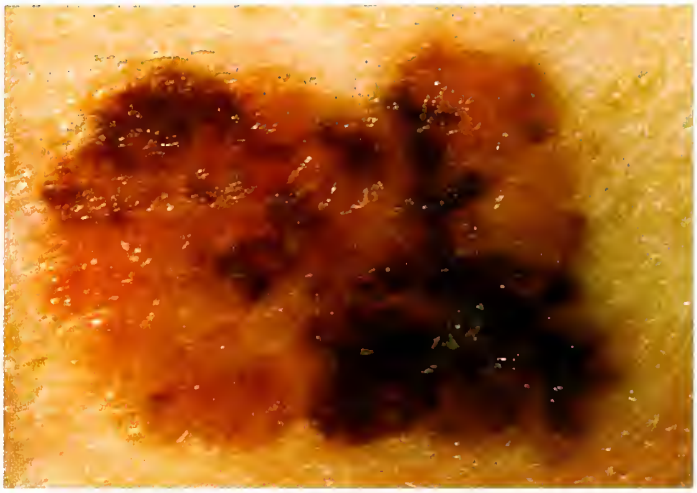
The MCQ paper for the April modules will be enclosed in next week's *C&D* covering:

- Haemorrhoids(48)
- Cholesterol (49)
- Lipid lowering drugs (50).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

The unhealthy tan

The Health Education Authority has been drumming home the message that too much sun can mean skin cancer. However, old habits die hard when it comes to sporting a 'healthy' tan, as Rona MacKie, professor of dermatology at the University of Glasgow, found out



Cutaneous malignant melanoma is the most serious form of skin cancer and arises from the pigment cells (melanocytes) of the epidermis. The other two are basal cell carcinoma and squamous cell carcinoma.

Basal cell carcinoma is the commonest malignant disease of the skin and occurs in areas damaged by ionising radiation or ultraviolet light, or in scar tissue. It rarely forms metastases but can invade and destroy local tissues. Death may result in rare cases where the carcinoma is left untreated and underlying structures, such as bone or cartilage, are destroyed.

The faster-growing squamous cell carcinoma can metastasise and is associated with damaged or chronically-irritated skin.

Incidence

In the UK, the annual incidence of cutaneous malignant melanoma is around ten new cases per 100,000 of the population. Since the 1960s, the incidence has been doubling every 15 years and the rate of increase appears to be higher in the elderly. However, there is recent evidence from Scotland, California and Australia suggesting that in younger people, particularly females, the incidence of melanoma has levelled off and may indeed be falling.

Epidemiology

Cohort studies of melanoma patients indicate clearly that the rise began in the 1930s and has continued unchecked until about 1990.

Epidemiology studies clearly indicate that the 'at-risk' individual is a fair-skinned, fair- or red-haired Caucasian who lives in a sunny environment and enjoys an outdoor lifestyle. Individuals of Scottish or Irish parentage who emigrate to places such as California, Australia and Israel all have a greater increased risk of all types of cutaneous malignancies, including malignant melanoma.

Early childhood sun exposure also increases the risk of cutaneous malignant melanoma. Studies have shown that migrants who arrive in Australia after the age of ten never acquire a risk of developing malignant melanoma as high as that in individuals born there.

Causes

The above factors strongly suggest that excessive exposure to natural ultraviolet light is a major aetiological factor in the development of malignant melanoma.

However, there is not the clear-cut dose response effect for melanoma which is seen in patients with squamous cell carcinoma – those at greatest risk of squamous cell carcinoma are those who have spent the highest number of hours in an outdoor environment over their lifetime. In melanoma, intermittent episodes of burning sun exposure appear more important.

There is currently keen interest in the hunt for melanoma susceptibility genes. Around 5 per cent of cutaneous malignant melanoma appears to occur in a familial setting, and in this group a third have an abnormality in the gene which controls the entry of cells into the cell cycle. This abnormality is also found in other tumours and is currently a field of active research and investigation.

Therefore, the overall hypothesis at this time is that the major environment cause of cutaneous malignant melanoma is excessive intermittent exposure of the skin of genetically susceptible individuals to natural sunlight.

Pathophysiology

Cutaneous malignant melanoma is an outgrowth of neoplastic melanocytes from the dermo-epidermal junction. Normal skin has a population of about one melanocyte for every ten basal layer keratinocytes at the dermo-epidermal junction. In melanoma, these cells undergo malignant change, and thereafter invade the dermis and deeper structures.

The prognosis for patients with cutaneous malignant melanoma varies directly according to the depth of invasion or tumour thickness at the time of surgery. So for patients who have tumours thinner than 1.5mm, the five-year disease-free survival prospect is over 95 per cent, whereas for those whose tumours have invaded to 3.5mm or deeper, five-year disease-free survival falls to under 50 per cent.

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 52), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JUNE 14, PROVIDES 1 HOUR OF CONTINUING EDUCATION

OBJECTIVES

- To appreciate the HEA's sun care message.
- To distinguish between malignant melanoma and other skin cancers.
- To be familiar with the appearance of malignant melanoma.
- To be aware of the pharmacist's contribution to its management.

Presentation

Early cutaneous malignant melanoma may be symptom-free. There is rarely any pain, and the only likely symptom is a slight change in sensation in a new or growing pigmentation lesion.

The Glasgow Seven Point Check is a diagnostic tool comprising major and minor features which indicates whether a pigmented lesion is likely to be a malignant melanoma.

The three major points are:

1 change in size of a pre-existing naevus (mole or birthmark) or appearance of a new pigmented lesion
2 change in shape of pre-existing pigmented naevus or of a new lesion
3 change in colour of a pre-existing pigmented naevus or of a newly-appeared pigmented lesion

Minor points include:

4 inflammation
5 oozing or bleeding from the lesion
6 lesion size of greater than 6mm
7 minor symptomatic change such as sensory change.

Patients with any of the major features should be considered for an excision biopsy to establish the nature of the pigmented lesion in question.

The most common clinical differential diagnoses of cutaneous malignant

Continued on PVI

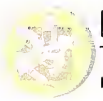
◀ Continued from PV

melanoma include benign melanocytic naevi and seborrhoeic keratoses.

The average young adult has 20-50 small benign melanocytic naevi or moles on the body. The vast majority of these have no pre-malignant potential and prophylactic excision is neither necessary nor logical.

Benign pigmented naevi are usually smaller than 4mm, have clear borders and are evenly coloured. In contrast, the early malignant melanoma has an irregular often almost geographical outline and may have several shades of black, brown and even red or blue blended within the lesion.

Seborrhoeic keratoses are benign overgrowths of the epidermal keratinocytes and are common on the trunk of older adults. They are usually multiple, have a raised warty appearance, are mildly itchy and can sometimes crumble.



Management

The appropriate management of a pigmented lesion on the skin which is thought to be cutaneous malignant melanoma is an excision biopsy and pathological examination.

Once the diagnosis of melanoma is confirmed and the thickness of the tumour has been measured, the need for further surgery will be established. Wider excision may be required, but modern surgical studies have shown that the very wide excisions and skin grafts of the past do not increase survival. The current working guideline is that excision margins should be 1cm in all directions for each millimetre of thickness, up to 3cm.

There is no proven adjuvant treatment for patients who have thick primary melanomas after surgical excision. At present, there are ongoing controlled multicentre trials assessing the value of both interferon and vaccines in this situation. Patients should be entered into these studies and managed at a centre with experience of melanoma treatment.

Monitoring

Once a patient has had one malignant melanoma, his or her chances of a second primary tumour are increased about 100-fold. Therefore, patients should have a total body skin examination at follow-up visits, checking the site of the first primary melanoma for local recurrence, and the draining lymph nodes for evidence of metastatic spread. The skin should also be checked for a second or subsequent primary tumour. The majority of second primaries are thinner than the first, indicating that a follow-up regime is worthwhile.

Pharmacist role

At present, the code of preventing malignant melanoma comprises four major points.

These are:

- avoid strong sun between 11.00am and 3.00pm, especially in a Mediterranean or warmer environment
- remember that clothing is an excellent sunscreen. A big cotton T-shirt and a broad brimmed hat protect a large proportion of the skin surface from excess UV
- seek out natural shade or create your own
- use high SPF (sun protection factor) broad spectrum sunscreens to protect against unavoidable sun exposure and redness.

Remember that sunscreens prevent sunburn and there is no evidence that they protect against cutaneous malignant melanoma. Indeed, studies from Australia and Europe suggest that excessive use of sunscreens which prevent the natural biological warning of sunburn can be associated with a higher risk of malignant melanoma. This is because many individuals use modern sunscreens inappropriately to allow them to spend long periods of time in intense sunlight.

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ACTION PLAN

1 In your practice workbook record all cases of patients presenting with new skin blemishes or changes in colour, size or shape of existing blemishes. What action have you taken?

2 Consider the sunscreen products stocked and note their protection factor. How effective are they at reducing UVA and UVB radiation? What are the relative merits of each type?

3 Develop a protocol for your assistants on suitable sunscreens for the different skin types.

Snore score

National Stop Snoring Week, held at the end of last month, highlighted a problem faced by 3.5 million people in this country and countless more indirectly. Marianne Davey, joint director of the British Snoring & Sleep Apnoea Association, outlines the condition

There are many reasons why people snore. Sometimes the cause is clinical: people who have suffered damage to the nose or throat, or who have problems such as a dilated septum or malformation of the lower jaw. In these instances, patients should be referred to their general practitioner.

However, other factors, such as age, health, gender and smoking, are often to blame and simple changes in lifestyle can alleviate the problem.

National Stop Snoring Week, which was run at the end of April by the British Snoring & Sleep Apnoea Association, highlighted the cause and effects of snoring and offered help to the 3.5 million snorers.

What is snoring?

Snoring is not a disease, rather a symptom of various clinical and pathological conditions, some minor, others more significant. When we breathe in, air enters through the nose and into the oropharynx, where it passes through a region of lymphoid tissue in a ring around the back of the nose and throat.

During the day the oropharyngeal muscles work to hold open the airway which allows air to travel through it easily, but during sleep our muscle tone is relaxed. The airway becomes narrower or partially obstructed, when breathing in, and the walls of the oropharynx (throat) begin to vibrate and produce the sound we know as snoring.

The actual noise of snoring is brought about by the tissues of the oropharynx and in particular those of the soft palate (roof of the mouth) and the base of the tongue set into intermittent vibration. In fact, the tongue plays a far more important role in the incidence of snoring than was once thought.

Moderate or severe snoring can be associated with increased respiratory effort and hypertension.

Obstructive sleep apnoea is a more serious condition that affects 40,000-100,000 snorers. It is a temporary closure of the upper airway, which can occur up to ten times an hour. Sufferers complain of daytime sleepiness and morning headache, and the condition can lead to cardiac arrhythmias or even sudden death.

Who is susceptible?

There are many reasons as to why this happens. The most common are overweight, clinically-significant obesity, smoking and alcohol. As these conditions are treatable by the patient, a better understanding of why they increase the likelihood of snoring will enable the patient

Continued on PVIII ▶

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 53), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JUNE 14, PROVIDES 1 HOUR OF CONTINUING EDUCATION

OBJECTIVES

- **To be aware of the problems of snoring.**
- **To distinguish between simple snoring and obstructive sleep apnoea.**
- **To be familiar with the effects of obesity, smoking, alcohol and allergies on snoring.**
- **To understand how sufferers and partners can be helped.**

PSORIASIS *movers*

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As Ointment or Cream,
the most prescribed psoriasis treatment in the UK.[1]
Patients like Dovonex. ***Clean and easy to use,***
it's not linked to the long-term fears of potent topical corticosteroids.
You'll like the way they keep coming back for more.

ibing information for Dovonex
n/Dovonex Ointment and Dovonex
Solution. Presentation: Dovonex Cream
s 50 micrograms calcipotriol per g (as
diate) Dovonex Ointment contains 50
rams calcipotriol per g Dovonex Scalp
n contains 50 micrograms calcipotriol per
dications: Cream/Ointment Treatment of
moderate plaque psoriasis affecting up to
of skin area Scalp Solution Topical
ent of scalp psoriasis Dosage and
nistration: Apply twice daily to the
d areas Maximum weekly dose should
eed 100g of Cream or Ointment or 60ml
Solution Not recommended in children or
ncy as there is no experience of use
Dovonex Scalp Solution is used together
vonex Cream or Ointment, the total dose
potriol should not exceed 5mg in any
e g 60ml Scalp Solution plus one 30g
t Cream or Ointment or 30ml Scalp
plus 60g (two 30g tubes) of Cream or
nt Contra-indications: Patients with
calcium metabolism disorders
ensitivity to any constituents Precautions:
not be used on the face Wash hands
plication Avoid inadvertent transfer to
often weak areas especially the face
Hypercalcaemia has been reported in
generalised pustular or erythrodermic
exfoliative psoriasis Less than maximum
weekly dose may be recommended which
rapidly reverses on cessation of treatment may
occur Drug Interactions No interaction
between calcipotriol and UV light No
experience of concomitant therapy with other
antipsoriatic products applied to the same area
Side Effects Cream Ointment Transient local
irritation and facial or perioral dermatitis may
occur Other local reactions may occur
Reactions reported with Dovonex Ointment
include dermatitis, pruritus, erythema,
aggravation of psoriasis photosensitivity and
rarely hypercalcaemia or hypercalciuria Scalp
Solution as above In addition local irritation of
the scalp or face may occur Use during
pregnancy and lactation: Safety for use during
human pregnancy has not yet been established
although studies in experimental animals have
not shown teratogenic effects Avoid use in
pregnancy unless there is no safer alternative It
is not known whether calcipotriol is excreted in
breast milk Overdose: Hypercalcaemia may
occur in patients with plaque psoriasis who use
more than 100g Ointment Cream each week not
has been reported at lower doses in patients
with generalised pustular or erythrodermic
exfoliative psoriasis Basic N.H.S. Price:
Dovonex Cream £8.15 30g £16.30 60g
£29.40 120g Dovonex Ointment
£8.15 30g £16.30 60g £29.40 120g
Dovonex Scalp Solution £22.28 60ml Legal
Category POM Product Licence
Holder/Numbers: Leo Laboratories Ltd
Dovonex Cream PL0043/0188 Dovonex
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1 IMS Medical Data

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to tackle the problem more effectively.

1 Effect of obesity

Neck obesity seems to be the most important factor in contributing to snoring. Individuals with a greater than average amount of fat located around the neck will not have the muscle tone needed to keep the airway open sufficiently at night to allow normal breathing, and the narrow airway is more likely to vibrate. A patient with a short, fat neck is likely to suffer obstruction at multiple levels in the oropharynx during sleep, giving rise to snoring.

For the snorer the notion that one can reduce fat around certain areas, or 'spot reduction' as it is termed, is a fallacy. Therefore, to lose weight around the neck area one has to lose total body weight.

2 Role of smoking

Smoke from cigarettes, cigars and pipes (including passive smoking) irritates the nasal mucosa, which results in catarrhal flow, as well as nasal passage congestion and hence snoring.

The nasal valve area is the narrowest passage in the respiratory tract. If this passage becomes congested with mucosa, nasal breathing is impaired. The congestion also creates greater negative intrathoracic pressure on inspiration. In addition, smoking provokes mucosal oedema (swelling) and inflammation, resulting in a narrowing of the pharynx.

Smokers tend to show a decrease in dynamic lung function, which in severe instances is manifested in obstructive lung disorders. Airway resistance at rest is increased as much as threefold in smokers following 15 puffs on a cigarette during a five-minute period. The increase in peripheral airway resistance with smoking is mainly due to the nicotine stimulating the nervous system.

There is evidence which shows that the toxic compounds in cigarette smoke may damage cellular components, and cause the release of histamine to counteract the effects of the smoke. Even passive smoking can cause chronic inflammation of the pharynx, thus increasing risk of snoring. In children, this is particularly pertinent. Evidence from one study suggests that even after tonsillectomy was performed to alleviate snoring, the condition still prevailed, with children of parents who smoke being most affected.

There is also dose-effect relation between the number of cigarettes smoked and the prevalence of habitual snoring. In former smokers, the prevalence of snoring depends on the length of time since stopping.

3 Role of alcohol

Within several minutes of entering the blood stream, alcohol travels to all areas of the body and slows the brain's responses. Blood vessels dilate, the flow of blood to the skin increases and the muscles relax.

These effects of alcohol cause the muscle tone in the oropharynx to relax in the first instance. This then results in negative inspiratory pharyngeal pressure which leads to the suction collapse of the oropharynx and consequently snoring. Indeed, alcohol intake can induce obstructive sleep apnoea in individuals who are otherwise just snorers.

Alcohol also depresses the arousal mechanisms that induce normal breathing and reduces neuromuscular tone in the upper airway muscles which leads to more frequent obstructions of the airway. As with smoking, intake of alcohol causes nasal airway mucosal engorgement, which increases the airway resistance on inspiration.

Ingestion of alcohol has also been shown to worsen nocturnal breathing abnormalities. In one study, subjects who did not usually snore snored persistently during the night following alcohol intake, with the intensity of snoring diminishing in the early hours of the morning. Subjects who normally snored, developed obstructive apnoea during the first part of the alcohol night, while subjects already suffering the condition of sleep apnoea had more frequent and consistently longer apnoeas during the night, following ingestion of alcohol. For all subjects alcohol reduced the stability of the upper airway, the magnitude of which depended on the amount of alcohol ingested.

Some sedatives, such as sleeping pills, depress the central nervous system and cause similar effects to those of alcohol.

ACTION PLAN

1 For the next ten patients who complain of snoring, note their appearance (weight/height ratio, sex, age). Can you draw any conclusions from this list?
2 Find out when snoring is at its worst (time, position in bed). Is alcohol, smoking or medication implicated?
3 Make a list of suggestions to alleviate snoring.

4 Allergies

Nasal congestion can be caused by other factors, for example colds, hayfever or other allergic reactions. Dust mite allergens in beds, for example, may be inhaled through the nose of the sleeper. This causes an allergic reaction in which the mucous membrane becomes inflamed and causes restriction of the airway. Often, the use of allergy-free bedding or antihistamines can alleviate the symptoms. Long-term use of nasal decongestants should be avoided and drug-free alternatives recommended.

Patient support

National Stop Snoring Week helps increase awareness of the problems of snoring and encourages sufferers and their partners to seek help. Pharmacists can help by offering lifestyle advice and identifying OSA and referring where appropriate.

Nasal strips, such as Breathe Right from 3M, are non-invasive external nasal dilators designed to be stuck by the bridge of the nose. They gently pull the walls of the nasal valves open to reduce airflow resistance, making breathing easier. Clinical trials have shown that the nasal strips reduce nasal airway resistance by around 30 per cent and can reduce or even eliminate snoring.

● **Useful address:** British Snoring & Sleep Apnoea Association. Tel: 01737 557997.

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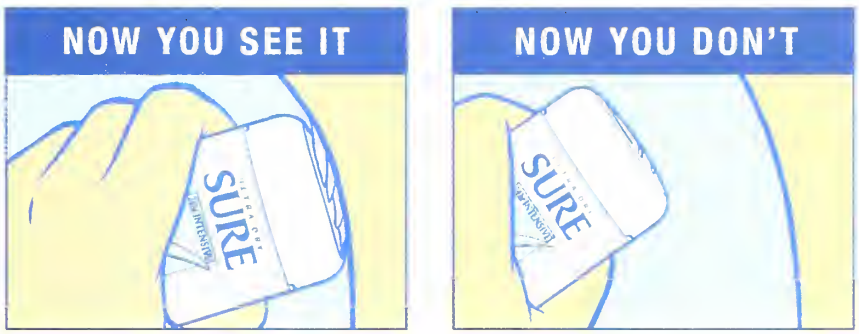

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ELIDA FABERGÉ

Question time for Council candidates

With a closing date of May 16, you still have time to make your mind up who to vote for in the Royal Pharmaceutical Society's Council election. This year, *C&D* asked candidates to respond to two topical questions: 1) Are you satisfied with the progress the Society is making with the 'Pharmacy in a New Age' and 'New Horizon' initiatives? 2) What are your views on the Health Plus prescription manager/ counselling system being offered by Practice Resource Systems?

Michael Burden

1 We are all the Royal Pharmaceutical Society. Some of us have made more progress than others. The Council has issued or commissioned a number of crucial reports – the challenge for us, the members, is to implement them. Most of the 'New Horizon' objectives require local action. There is still much to do, but we cannot afford to miss the opportunity.
2 The harnessing of IT to enable pharmacists to provide better pharmaceutical care is an imperative. It would be unwise to opt for one provider at this stage. We should encourage the Department of Health to develop freely accessible networks which link all health professionals and allow the pharmacist to play a full part in the primary healthcare team.

Michael Burden, pharmaceutical consultant and pre-registration consultant for NHS Executive Trent, from Leicester

D Hopkin Maddock

1 Council is misguided in its 'New Age' endeavours. Its recent, vital 'Information Technology' report is already years out of date. Its standards don't mention authentication, a critical tool for secure transactions. Is Council aware hundreds of pharmacies are being traded in the City? Here the hallmark is high share price. Pressures are being exerted on pharmacists to increase profits by reducing staff costs – life is becoming more stressful. Professional standards must suffer – will the 'New Age' benignly disappear?
2 It is difficult to comment on the Health Plus system as succeeding presentations continue to vary. Community pharmacy could be totally undermined. We must resolve:
i) The integrity of the system/patient confidentiality. Secret contracts exist with industry over counselling. No one gives away money for nothing – what will they receive?
ii) A forced offer to other suppliers to use or adapt software at considerable expense, may be anti-competitive.

Mark Koziol

1 My feelings are mixed. I am delighted that the Society has devoted a considerable amount of time and resource to the project and that it has appointed Philip Green to be the 'New Horizon' project manager. I have grave misgivings, however, that powerful 'New Horizon' opponents still occupy so many Council seats – the process could still be derailed.
The process will benefit if:
i) Lambeth bureaucracy is replaced by an outcome-orientated management system.
ii) Local communication with grass roots pharmacists is underpinned by local facilitators.
iii) Presidents and vice presidents of the Society are chosen on the basis of their support for 'New Horizon'.
2 Few people envisaged the 1983 Council ban on handwritten labels would spawn widespread computerisation, from which have evolved the multifaceted beneficial uses of today. An electronic pharmacy-surgery link will represent another singularly significant event

Mark Koziol, part-time locum pharmacist, founder of Provincial Pharmacy Locum Services, the Pharmacy Insurance Agency and PPLS (Holdings), and editor of *The Locum*, from Birmingham

from which will derive numerous benefits, many of which, as yet, have not been thought of. Subject to the inevitable developmental issues that the Health Plus innovators will need to address to dispel initial concerns, the concept is an extremely exciting one offering enormous opportunities.

Gordon Appelbe

1 The Council set itself an onerous set of targets and has already produced a series of reports since the 'New Age' began, eg Pharmacy Practice Research. Some of its views have been reflected in the NHS (Primary Care) Act. We are dealing with a mid- to long-term initiative and much more remains to be done. I am encouraged by the progress made, much of it due to those pharmacists, the co-ordinators, who took up the challenge and arranged the series of meetings with the membership. So far so good, but it is essential that the motivation and momentum should not flag.
2 Many professional and legal concepts remain to be considered. These include compatibility with existing pharmacists' systems, availability, cost, patient registration and existing legal impediments. The question of patient choice and informed consent, together with confidentiality of data, whether personal, anonymised or aggregated,

Dr Gordon Appelbe, independent pharmaceutical/legal consultant and co-author of 'Dale and Appelbe's Pharmacy Law and Ethics', from London

is fundamental. Equal treatment of pharmacists and doctors is important, together with the fact that recruitment of patients should be with the pharmacist. It is essential that pharmacists embrace the technological age and in that regard the PRS scheme is a potential step forward in patient care.

Dr Hopkin Maddock, locum and secretary of Cornwall & Isles of Scilly LPC, and consultant to the DoH, from Padstow, Cornwall

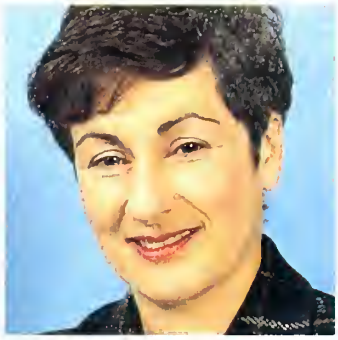
iii) GPs in a town with, say, four pharmacies, could accept free computers but the pharmacies could refuse to take part. Only Health Plus pharmacies would be advised (anti-competitive?), and any of these could dispense the repeat prescriptions with the agreement of the GP – regardless of distance, ie mail order repeat dispensing.

Ted (A E) Smith

Ted Smith, community pharmacist and area manager for Boots the Chemists, from Nantwich

1 I am supportive of the aims of the 'New Age'. Within a rapidly changing world, the profession needed a robust structure for the future. I welcome the 'New Horizon' which highlights the extent to which we must move forward. I remain disappointed with progress. I am not convinced the Society is giving adequate resources to the delivery of the 'New Age', and wish to see prioritisation of the important issues – professional standards, remuneration, definition of range of services and the production of innovative IT solutions. It is also critical that development of pharmacy practice research is accelerated. There is much to be done to demonstrate the value of pharmacy.
2 I strongly support development of IT and systems within pharmacy. There must be, however, a level playing field on which all can take part, where patient choice is safeguarded and where appropriate information is available to the pharmacist. Until a system has the full support of the pharmacy and medical professions, as well as the NHS, it should not be introduced. I am not yet convinced that the Health Plus system meets these criteria.

Linda Stone



Linda Stone, community pharmacy locum, from Solihull

1 No, I am not satisfied. Although we have made excellent progress in some areas, in others we have not. We must resolve the lack of resources, including the remuneration structure. We need a clear focus on the method of delivery, and the Society must accept the need to change its structures and mode of work. This must be achieved without losing existing strengths. The initiatives have heightened awareness of the need to change and develop, and clarified perceived strengths and weaknesses, and areas in which we may progress. Most importantly, we must unite if we are to deliver these aspirations.
2 For pharmacy to progress, it is vital we are linked into the NHS network. Whatever pharmacy system is used must satisfy certain criteria. We must be able to access clinical information to deliver pharmaceutical care. The system must be secure, particularly against the 'sale' of data. We must resist any commercial pressure to direct and reduce our professional discretion when counselling. In embracing such highly-sophisticated technology, we must not compromise our integrity. I need reassurance that this, or any other similar system, satisfies my concerns.

Mel Smith

Melvyn Smith, industrial pharmacist and professional relations manager for Reckitt & Colman Products, from Keyingham, Yorkshire

1 I feel that the 'New Age' initiative marked a major change in the actions of the Society. This proactive approach to the future of the profession is long overdue. I am, however, concerned that the results of the deliberations are taking so long to disseminate. The second Newsletter is only just being circulated. I am also concerned that PIANA should not be seen as the answer to all the problems of pharmacy in the future.
2 I am in favour of anything that improves the service to the patient and makes better use of the healthcare professional's time. I approach all commercial undertakings by asking 'what is the company's motive for doing this', or 'who pays and for what?' The information I have read so far does not add up! My concerns are that small community pharmacies will not get value from the system. The workload will be greater than the benefits and the nature of the system will not encourage closer co-operation between the pharmacist and other healthcare professionals.

Joanne West

Joanne West, proprietor pharmacist, CPPE tutor and pharmacy facilitator for Lincolnshire HA, from Boston, Lincolnshire

1 The two initiatives have enabled us to determine the direction in which the profession needs to go to ensure its future. The workload involved is phenomenal; so far the membership and interested parties have been canvassed, working parties have been set up and reports produced. This work now needs to be focused into a strategy for the future. What the Society must ensure is that the membership does not feel the momentum has been lost. Every opportunity must be taken to keep all interested parties informed of the very definite progress being made.
2 I can see great benefits to patients using a system such as Health Plus. I congratulate Practice Resource Systems. We now have the NHS Executive addressing the issue of a computer link between surgeries and pharmacies, strengthening the position of pharmacy in healthcare. The system, and any others like it, must be affordable to *all* pharmacies. I would like to see the system marketed equitably to promote the pharmacy-surgery relationship.

Marie Stainton

Marie Stainton, independent pharmaceutical consultant from Sandy, Bedfordshire

1 Yes I am. We must move forward, but change takes time. The proposals in these documents are welcome and they are linked to clear deadlines which strike a balance between the time needed to develop a well thought-out plan and a headlong rush which could lead to disaster.
2 Computer links between GPs and pharmacists are not only desirable but inevitable. Although exciting in concept, Health Plus has serious drawbacks:
- it seeks to charge pharmacists but is free to GPs
- if pharmacists are to be authoritative experts on drugs and offer pharmaceutical care to all, then it is essential there is equity of access to this care for all patients. They must be given the same standard of impartial advice, whatever their medication
- their confidentiality must be respected totally
- any computer system enhancing communications between GPs and pharmacists must be equitable and promote evidence-based medicine by allowing two-way exchange of information. Health Plus does not seem to offer these benefits.

Nicholas Wood

Nicholas Wood, community pharmacist, from Brentwood, Essex

1 'Pharmacy in a New Age' is a dynamic and ongoing process. This week (April 7-11), I and other Council members met to plan future strategy, recognise where we have made progress, and seek out what still needs to be done. We identified areas where the Society needs to do more – for example, by working for change in the remuneration system. But some things have been achieved already, not least encouraging the profession to respond to change. Nevertheless, there is no place for complacency, and maintaining the momentum of the 'New Age' has to be our top priority.
2 The Health Plus System, when first presented to Council, was potentially a huge threat to community pharmacy, and I strongly criticised it at the time. This week, I made it my business to see a demonstration of the new revised system and, while still sceptical, I am now satisfied that it no longer offers the threat of prescription direction or control by doctors. We need to remain vigilant, but the Health Plus system now appears to be largely a communications tool linked to a national patient database, and not a threat to the profession.

Alan Woodcock

Alan Woodcock, proprietor pharmacist, from Southport

1 I am pleased at the lengthy consultation process and the ongoing questioning of local contacts in order to gain the present 'picture' of professional interactions. If the profession is to progress and take up the opportunities on offer, it is necessary to know one's starting position. Progress so far has identified areas worthy of strategic development, and with whom. If pharmacy does not 'grasp the nettle', other professions will. It is essential that, long-term, the Society, NPA and PSNC are in fundamental agreement and it would be advantageous for someone like myself with interests in all three organisations to be on Council.

Council members should be responsive to a proactive membership and not just air personal views. It is pleasing to note that Council and PSNC are now in agreement on some remuneration matters. In general, I am satisfied with the progress of initiatives to date.

2 Very little debate is needed on this subject. I see little or no benefit to patient care. It is a potential extra expenditure for pharmacy and may restrict patients' freedom of choice. Even with the revamped proposal, I see the only beneficiaries being Practice Resource Systems and it could be the thin end of the wedge. Patients receive one to one counselling already, plus the contact with surgery and pharmacy staff.

Hassan Argomandkhah

Hassan Argomandkhah, proprietor pharmacist and Numark business lecturer in pharmacy management, from Liverpool

1 PIANA has been the most successful attempt by the profession to move pharmacy's agenda forward. It has been heart-warming to see other observers, such as the Department of Health, being influenced by our agenda. The DoH has now incorporated this into its health service White Papers. The next stage is critical. Council will be producing its final strategy document. This will announce our policies and how we aim to achieve them. I aim to ensure this final document is both relevant and achievable, without jeopardising the future of community pharmacy.

2 As a pharmacist, I will always welcome new advances in technology. However, as a member of Council charged with protecting the interests of the profession, I do not wish to pre-judge the outcome of the joint meeting between the RPSGB and the BMA. I believe the future will be better served if the network connecting doctors and pharmacists is part of the full NHS net.

Peter Curphey

Peter Curphey, independent proprietor and vice president of the RPSGB, from the Isle of Man

1 An exercise as innovative, complex and fundamental as PIANA will progress at differing speeds according to what is being tackled. The volume of material we have produced for ourselves and others is incredible. We could have cobbled together attention-grabbing headlines to ensure pharmacists retained their enthusiasm, but an element of trust is now necessary. The strategy we unveil in September will give a new optimism to a profession in the ascendant. The most difficult will be the management of change and calming the accompanying uncertainties. We are on target!

2 The fate of community pharmacy can only be assured if it encompasses access to and sharing of information. That can best be achieved within an *open* access IT network, where all primary care professionals work together in patients' interests. Any system which perpetuates traditional battle lines, which diminishes the pharmacist's role, which coincidentally threatens income and the network's existence, is of doubtful value. If it also alarms prescribers on confidentiality, waste and patient consent, then it is wrong. If Health Plus can avoid these pitfalls, it will be welcomed; if not, it will not.

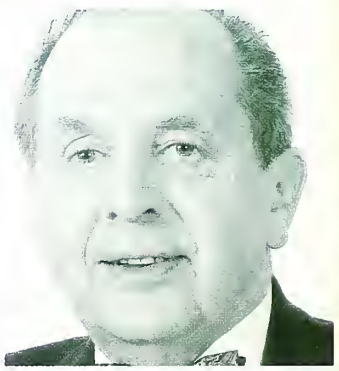
David Kent

David Kent, community pharmacist and secretary of Camden & Islington and Kensington, Chelsea & Westminster LPCs, from London

1 One can only be dissatisfied with progress made. The report on what must be one of the most pressing issues – that of rational distribution of pharmacies – which should have been published in December, 1996, has yet to surface. The most serious issue – adequate professional remuneration for both existing services and proposed new roles – is not touched on at all.

2 PRS seeks to profit from manipulation of the present system of prescription generation and dispensing. The PRS system leads to direction of prescriptions which is contrary to GPs' NHS contracts. Once signed up to the scheme, the right of the patient to present prescriptions other than at their designated pharmacy is removed. The PRS system is 'de facto' registration of patients with pharmacies. Participating pharmacies will expect to increase prescription numbers at the expense of those which cannot justify participation on economic grounds. The fact that certain large companies are considering participation must be treated with concern. For these reasons, and many others, the PRS proposals must be rejected.

John Balmford



John Balmford, locum pharmacist and auditor for the RPSGB, from Dereham, Norfolk

1 Council has set a heavy workload in its 'Pharmacy in a New Age: the New Horizon'. Existing pressure on staff times means progress is not being made as rapidly as I would have liked, in view of the funding crisis facing many smaller independent contractors. The 'Agenda for Action' is good, wide-ranging and parallels the Department's own vision for the future. There will be increasing opportunities for local negotiation of contracts for professional services. Such negotiations must be carried out by LPCs representing *all* contractors in the area. The new contracts must be financed from a new source of funding – for it to come out of the professional allowance would destroy small pharmacies.

2 I am not happy with the probity of the system, it being a commercial contract. It could undermine the Government's will to set up a system. The system we need would link hospitals, GPs and pharmacists together with other organisations, such as the PPA and health authorities, so that rapid, but limited access, could be obtained. What is to prevent repeat prescriptions being diverted away from the originating pharmacy in the future? Repeats account for 60 per cent of all prescriptions. The loss of even some could jeopardise the funding of pharmacies. I do not believe it is the correct solution and could lead to abuse.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.and we intend to support community pharmacy throughout
is year with exciting new business developments in Vantage."
ALAN TURNER
MARKETING DIRECTOR
AAH
PHARMACEUTICALS
LIMITED
We will be will
We're always there, we always care.

Elections have rules ...

You will no doubt be aware by now that a canvassing 'newsletter' in support of Ted Smith (a prospective Royal Pharmaceutical Society Council member) has been sent from Peter Walker, chairman of the Boots Pharmacists' Association (JBPA), to all Boots' pharmacists, even if they are not JBPA members.

In it Mr Walker states: "It is our opinion that this far-reaching experience [in BTC management] makes Ted an eminently suitable BTC candidate" and "It is vitally important that we have a voice on Council in support of Marshall Davies".

The rules which govern Council election procedure state 'Candidates are expected to refrain from any personal canvassing or from requesting or giving permission for canvassing to be done on their behalf. Candidates who become aware that any person, group or organisation intends to canvass on their behalf will be expected to make every effort to dissuade those concerned from doing so'.

Mr Walker went so far as to submit Mr Smith's statement of policy. No other candidate was mentioned. The memo also states Mr Smith only needs 1,300 votes to ensure success, "Vote now remembering that first preference votes are the ones that count".

This is shocking. Pharmacists must show distaste at such underhand tactics and say enough is enough. I hope, too, that Boots' pharmacists will show their disagreement with this tactic.

In his senior position as an area manager, Mr Smith surely must have been aware of what was happening?

As the election procedure says: 'Any candidate who appears to breach the signed declaration will be required to give an explanation to the president and the Council as to why they allowed a breach of the protocol to occur'.

I would like to see this go further. I would like to see Mr Walker resign as JBPA chairman. Mr Smith must surely do the honourable thing and step down now.

The JBPA has got away with enough. Let's see what the RPSGB intends to do.

S Dajani
Durrington, Wiltshire

Persona's BBC body blow

It seems that, with the help of the BBC television programme 'Watchdog Healthcheck', the majority of community pharmacies have had a lucky escape.

Last Thursday evening's edition has probably dealt a damaging, maybe even fatal, blow to Persona. Although the programme was unbalanced, as it did not provide significant evidence for widespread failure of Persona, the confidence of potential users will have been destroyed.

Thankfully, I and many others will not have to worry about expensive, unsellable stock, damaged reputation, concerned customers or possible legal action.

Thank you, Unipath, for having the foresight to protect the majority of pharmacies from the fallout following Persona's almost certain demise.

Tim Cottingham
Grimsby

The Birdsgrove experience

I have not many regrets in my 62 years since qualification, but having returned from a week of rest and relaxation at Birdsgrove House I do regret that I have not taken advantage of it in the past, particularly as its unique character is under threat.

Without doubt, one of the Royal Pharmaceutical Society's greatest assets is this fine old mansion. How many Council members and potential Council members have stayed there and, if not, how can they make the right decisions about its future?

It is sad that Birdsgrove House is not used to capacity, and I think this is partly due to poor marketing by the Society. I had no idea how simple it is to organise a stay there. Just pick up the telephone, dial 01335 342144, and speak to the manager, Joyce Evans.

Access to Derby by road and rail is easy, and a staff member will meet you at the station. The house is warm and comfortable – a warmth which reflects from all the staff, making it more like a visit to relatives than a hotel.

Everywhere there are decorative reminders of ancient pharmacy, with jars for tamarinds and leeches, etc, and a large brass pestle and mortar.

There is a lift for those who find the stairs to the bedrooms too difficult. There are two lounges, and another reception room has a full-size snooker/billiard table. The three televisions give guests a choice of programmes.

A stay with breakfast, lunch and dinner included costs £145 a week plus VAT.

The house itself is situated in extensive parkland. On the spacious lawns there is putting and croquet, and many seats in sheltered spots.

Birdsgrove House is a pharmaceutical jewel. It is an antidote to relieve the stress of modern pharmacy.

There are over 30,000 pharmacists on the register. Surely this house can be supported and maintained by so many? What a tragedy to lose such an asset.

Athol E Varley
Bridlington, East Yorkshire

Taking stock of out of dates

I am grateful to **Xrayser** for highlighting the growing problem of stock expiry dates. It is particularly annoying when expensive dispensary stock goes out of date when another pharmacy could have used it quickly.

The 'excess stock' free adverts in *C&D* are useful. However, an Internet-based swapping system could probably save us all a lot of money and reduce pharmaceutical waste.

May I ask if anyone knows how much the average UK pharmacy loses each year due to stock going out of date, and what others propose to help reduce this problem?

Graeme Park
Johnstone

Undeserved bad press?

I was disappointed with **Xrayser's** recent remarks about the Health Plus system (*C&D* April 5). It is evident that **Xrayser**, like so many others who have criticised PRS, has not actually seen it.

While I agree that the introduction of electronic links between GP surgeries and community pharmacies will elicit a fundamental change in practice, one should not assume that all change is negative.

There are many within the profession who would welcome the prospect of patient registration to pharmacies as a considerable step forward. Moreover, the advantages at being able to provide an interaction check to ingredient level on all OTC medicines against a patient's prescribed medication at any Health Plus pharmacy is self-evident.

The registration process, initially undertaken in the pharmacy, will ensure collaboration between prescriber and pharmacist on repeat cycles of medication, and further enhance the profession's role in medicine management.

The introduction of new revenue streams for contractors for counselling patients on medication (up to £15 per session) provides a remunerative model which will help facilitate the implementations of the Society's document, 'From compliance to concordance'.

To suggest that there is not a level playing field for all contractors is simply untrue. PRS agreed to publish the interface codes enabling existing suppliers to join the Health Plus network. We will enter the market place with one of the most competitively-priced systems at the leading edge of computer technology. Each contractor will have to weigh up the undoubted benefits the system will offer both patients and business.

There have been many that have sought to twist the facts. The reality is that Health Plus is not a pharmacy labelling system but a medicine management tool which will enhance and reward the professional role of the pharmacist.

While I can understand the concerns, closer examination of what the system offers will show that these are misplaced. Contrary to **Xrayser's** claims, the Health Plus system will provide a platform of opportunity that will propel this profession forward.

Andrew Burr
Director of professional services, PRS

Fond memories

I am writing to you following the unexpected death on April 9 of Ros Boulstridge, who was marketing director at Crookes Healthcare.

Crookes has been one of our major clients since 1981 and, since Ros joined in 1990, we enjoyed a close working relationship with her, with several of my team progressing alongside her and learning a great deal from her strategic vision. She was always a wonderful client – well liked and respected by all who worked with her. She had a tremendous energy and drive, and her enthusiasm was infectious.

She inspired great loyalty in all those who worked with her and will be sadly missed by all members of the healthcare team at Maureen Cropper Communications.

Maureen Cropper
Managing director, Maureen Cropper Communications

Pierre Fabre opens up UK subsidiaries

Pierre Fabre, one of France's largest privately-owned pharmaceutical and dermo-cosmetic companies, has set up two UK subsidiaries: Pierre Fabre Oncology and Pierre Fabre Research. Both are based in Winchester, where they have 18 employees.

Martin Grange, formerly marketing manager of Eli Lilly, has been appointed managing director of Pierre Fabre Oncology. Its first UK product, scheduled to be launched next month, will be Navelbine (see p8), a chemotherapeutic agent to treat non-small cell lung cancer and advanced breast cancer.

Mark Hibberd, PF's clinical research director in the UK, says it wants to introduce other treatments for Parkinson's disease, depression, hyperlipidaemia and prostrate problems.

The company, owned by its founder Pierre Fabre, already has subsidiaries in Spain, Germany, Italy, the US and the Benelux.

Its turnover last year was close to Fr6 billion – its annual sales have been growing by about 8 per cent, partly because of the success of new products developed by Pierre Fabre Research and licensing agreements with other pharmaceutical groups.

United Norwest buys in

United Norwest Health Care has moved into Wales by acquiring two pharmacies: B M Price and R I Williams in Rhosllanerchrugog, near Wrexham.

AAH takes on Genus

Genus Pharmaceuticals' range of multisource products is due to be distributed by AAH Pharmaceuticals from May 1.

Glaxo licensing deal

Glaxo Wellcome has signed a licensing agreement to allow Novopharm to launch a generic version of Zantac 16 days before the drug's patent expires.

Astra pulls out

Astra has stopped dealing with Huntingdon Life Sciences, one of the UK's largest research laboratories for animal studies, following a television programme's allegations about how Huntingdon treats its animals.

Zeneca deal

Zeneca Pharmaceuticals is collaborating with Oxford University to identify genes responsible for ischaemic heart disease.

Michael Ward is new boss of AAH/Lloyds empire

Gehe has set up a executive committee to run AAH/Lloyds and it will relocate the group's head office to Coventry.

The moves represent the company's first major restructure since it acquired Lloyds.

Michael Ward, former managing director of Lloyds Chemists, has been appointed chief executive of the committee. It has four other members: Stefan Meister, group finance director; Michael Major, managing director (retail); David Taylor, managing director (wholesale); and Graham Kershaw, group human resources director and group company secretary.

Martyn Hardy, who was appointed on Lloyds' restructured board soon after the acquisition, has been made redundant.

AAH/Lloyds' new HQ is a 65,000sq ft office block, called Sapphire Court, based at Coventry's Walsgrave Triangle business park.

The relocation is set to start in a couple of months to give Gehe time to refurbish the offices, which are being leased.

AAH's group head office in Manor Park, Runcorn; Hills' head office in Hook, Hampshire; Lloyds Retail Chemists' head office in Atherstone, Warwickshire; and various group divisions, such as purchasing, property and marketing, will move to the new HQ.

AAH Pharmaceuticals' head office and Gehe's computer division will remain in Runcorn.

Lloyds' 72,120sq ft warehouse in Atherstone, and its staff, remains unaffected.

Mr Ward will relocate temporarily from Lloyds Chemists' HQ in Dostill, Tamworth, to AAH's head office in Hampton Court, Runcorn. He will move to Coventry next summer. The Tamworth offices are being closed.

AAH/Lloyds' staff were told about the moves on Monday.

Most of Hills' 70 head office staff will be made redundant over the next six months. A few will also be made redundant at AAH's and Lloyds' head offices.

Mr Kershaw says: "For those who, regrettably, face redundancy we are putting a number of measures in place to do our utmost to help them find alternative employment. It is inevitable that when companies merge there is an element of unnecessary duplication."

Dr Karl-Gerhard Eick, Gehe's finance director, says the restructure makes geographical sense. "Logistically, it's a good decision. If you think where the centre of the UK is, it's in the Midlands. The new headquarters will improve communication between the whole [UK] organisation," he says.

Retailing and distribution changes stemming from the integration may not occur for another 6-12 months, he adds.

The integration is gaining momentum. Colin Wilson was recently appointed group buying director of AAH Pharmaceuticals/Lloyds and Gehe is selling Lloyds' 'non-core businesses', including Holland & Barrett and Martindales Pharmaceuticals.

Last week, Gehe met the legal requirements for acquiring Lloyds by selling six Daniels' depots to Philip Harris Medical and George Foster.

Michael Ward is AAH/Lloyds' new chief executive

Numark share option for income rebates

Numark shareholders can now opt to have a proportion of their rebate income paid in new Numark shares.

Each new share will be worth £1. Terry Norris, the company's managing director, says the option was decided on after requests from shareholders.

Shareholders will still be entitled to only one vote, no matter how many shares they own.

Members of the buying group will also be able to vote by proxy from now on at annual and extraordinary general meetings.

Numark's shareholders voted to offer a proportion of their income rebates as new Numark shares at the company's AGM in Blackpool

Chirotech lifts Chiroscience

Chirotech, a subsidiary of Chiroscience, helped to lift its parent's revenues by 133 per cent to £11.5 million for the year to February 28.

Chirotech's sales rose 270 per cent to £9.2m during the period, compared with those of the previous financial year. Sales of lactam earned £6.5m.

During the year, Chirotech launched (S)-naproxen, a non-steroidal anti-inflammatory drug; and Duphos, a technology for catalytic assymmetric synthesis.

Chiroscience's group net loss rose 61 per cent to £18.7m, mostly because its research and development expenditure grew 84 per cent to £22.2m.

However, it is optimistic about the new financial year, despite City investors being unimpressed by increased R&D spending – shares fell 17.5p to 335p after results were announced.

Hoechst moves OTCs to Seton

Hoechst Marion Roussel has transferred its UK and Eire OTC portfolio to Seton Healthcare.

The move is part of HMR's strategy, announced two years ago, to concentrate on prescription medicines and to move away from OTCs and generics.

Under the agreement, which runs for ten years, Seton will handle the UK sales and marketing of Syndol, a treatment for tension headache; and the Merocaine, Merocet and Merothol range of medicated throat lozenges. The brands are worth more than $4 million.

Seton will pay $2.4m to exploit the brands' manufacturing and technical 'know-how', plus their product licences, over the first two years of the agreement. It is also paying HMR an undisclosed commission on sales during the ten-year period.

At the end of that time, Seton has the option of acquiring the brands, but can only do so if it gives HMR two years' grace to change its mind and buy them back.

Dieno George, Seton's deputy chief executive, says the deal strengthens its portfolio. "If you take Syndol, coupled with Paramol and Transvasin, we'll have a 20 per cent share of the strong analgesic market in pharmacies," he says.

Seton, he adds, also has a "strong cough franchise" with its Meltus range. This will complement neatly HMR's medicated throat lozenges.

Seton will invest heavily to promote and market Syndol and Merocaine. It will spend $1m on both this year.

The company will probably repackage Syndol over the next two to three years, although it is keeping its options open on Merocaine.

HMR's agreement does not include the terfenadine range, Triludan, Triludan Forte and Seldane, because the Committee on Safety of Medicines is proposing to make all terfenadine antihistamines Prescription-Only products. HMR will continue to handle the brands until the CSM has officially ruled on the matter.

NPA: making connections for pharmacists

The National Pharmaceutical Association is offering a bespoke software package to put members on the Internet.

NPA-Connect comes with a number of options, from a simple e-mail service to unlimited access to the Internet for $10 a month (this does not include the cost of the local telephone call to access the service provider).

Other facilities include a ready-made bookmark file, giving access to other pharmacy-related sites, such as *C&D's* dot-pharmacy, and a dedicated support line.

Minimum system requirements are a 486PC with 8Mb of Ram running Windows 3.1 or 95, and a modem. The NPA is offering a Multitech V34 modem (28,800bps) for $99 or the US Robotics Sportster (33,600bps) at $149.

For an e-mail service the only cost is $10 for set-up and a $60 annual subscription.

The Internet service comes with two options. Level 1 subscribers get up to 3mb of space on the NPA's pharmacies.co.uk server, where they can create their own site. The annual charge is $120 (no set-up fee).

Level 2 provides a unique registered domain with up to 5mb of space for a website. The cost is $100 to set up, with a $400 annual fee. This does not include the mandatory domain name registration fee of $40 per year.

SB builds its pharmaceutical future

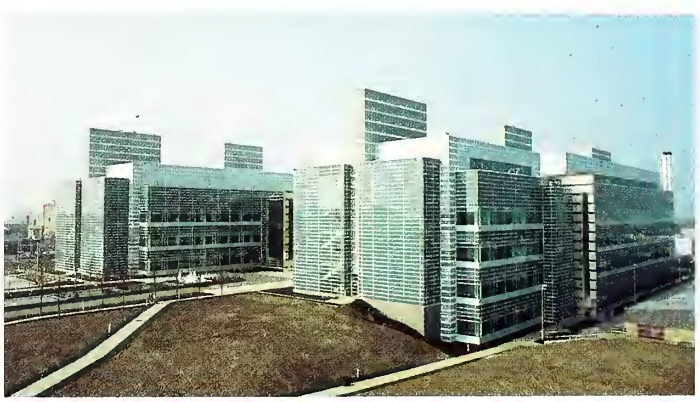
Smithkline Beecham opened New Frontiers Science Park, its new $250 million research and development centre, in Harlow, Essex, last Monday.

The official opening was the culmination of three years' labour, bringing together more than 2,000 SB scientists and support staff from eight R&D sites throughout the UK. The company is keeping its facilities in Tonbridge and Welwyn. It spends $1.93m on R&D every day.

The new Pharmaceutical Technologies building and Science Complex One represent the largest construction project ever undertaken by the company.

New Frontiers Science Park is spread over two campuses on 67 acres. DNA and neuroscience research, focusing on atherosclerosis, diabetes and obesity, will take place on the North campus, and development work on the South campus.

- Elsewhere in the world, the company is investing $79m in two R&D and one production and packaging facilities in Belgium, and has completed the first stage of redevelopment of its R&D site in Rennes, France.



Boehringer 'very satisfied' with 1996

Boehringer Ingelheim's UK over the counter division, Windsor Healthcare, increased its sales 9 per cent in the financial year to the end of 1996.

However, BI vice chairman Professor Rolf Krebs tells *C&D* that Windsor Healthcare could be more profitable if the company had more volume.

"We are going to introduce more products [to the OTC business]," he says. "We have defined this range, which will be coughs and colds, phyto-pharmaceuticals, laxatives and analgesics, as well as strong local brands."

Although Professor Krebs does not see the UK OTC market as a key area at the moment, he says: "In the long-run, I think the UK will be attractive, because besides the US, the UK Government is the most progressive in shifting safe products from prescription to OTC. We see opportunities in the UK, provided we introduce and register some of our new compounds."

The company's annual results were announced in Frankfurt last week. UK ethical sales rose 20 per cent, and sales to hospitals rose 25 per cent. BI's new non-steroidal anti-inflammatory drug, Mobic, launched in the UK in September, 1996, had sales of $1.4m and achieved a market share of 2.5 per cent by the end of the year.

Atrovent, the respiratory anticholinergic agent, Mobic and two other drug launches helped boost BI's worldwide sales by 10.2 per cent to almost DM7.1 billion.

For the first time, Atrovent sales exceeded DM1bn. Mobic has also exceeded expectations in its first year. Viramune, BI's new AIDS treatment; and Alna, for benign prostatic hyperplasia, also performed well.

Although net return on sales rose to 4.6 per cent, BI chairman Dr Heribert Johann said that the company's sales grew only 2 per cent in Germany overall, falling from a figure of 7 per cent earlier in the year, mostly because of the country restructuring its health policy.

"We are very satisfied with the business year 1996," he said. BI's income after taxes rose 20 per cent to DM54m. Return on sales was 4.6 per cent and return on shareholders capital rose from 9.2 per cent to 9.8 per cent. Human pharmaceuticals accounted for 84 per cent of sales. Of this, Prescription-Only products totalled 87 per cent.

Following the purchase of Pharmaton and the Canadian vitamin and mineral firm Quest, BI will continue to build up its phyto-pharmaceutical business.

COMING EVENTS

TUESDAY, MAY 6

Oxfordshire Branch, RPSGB
Visit to Bodleian Library, 6.45pm.

Bath & District Branch, RPSGB
AGM at Pratts Hotel, Bath, 8.30pm.

THURSDAY, MAY 8

West Metropolitan Branch, RPSGB
Macrae Room, 2nd Floor at St Mary's Hospital, London W2, 6.45 for 7.30pm. AGM followed by a joint meeting with the NPA, 'Drug, therapy and travel' by Dr Joe Brookes, medical adviser, Trailfinders.

West Hertfordshire Branch, RPSGB
Postgraduate Medical Centre, St Albans City Hospital, St Albans, 7.30 for 8.00pm. AGM followed by 'Continuing professional development' by Alan Nathan, Council member.

Classified

Appointments £26 P.S.C.C. + VAT minimum 3x1
General Classified £24 P.S.C.C. + VAT minimum 3x2
Box Numbers £12.00 extra. Available on request.
Copy date 4pm Tuesday prior to Saturday publication.
Cancellation deadline 10am Friday; one week prior to insertion date
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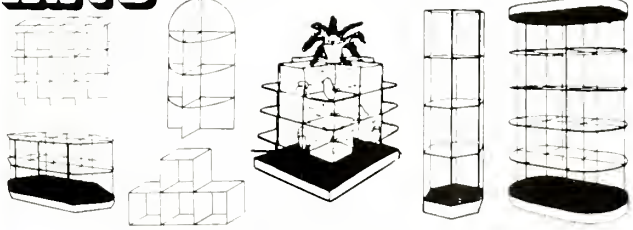

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FOR SALE

NOMAD CASSETTES - plus consumables at reasonable prices, also Hollister 3119 x 2 box at 40% Tel 01624 673942

KONICA MINI LAB QA - Good condition price £15k ono. Tel 01622 717141

NUMBER PLATE - Exclusive pharmacy number plate P11 MCY Tel 01268 565111

PRESCRIPTIONS SIGN - Illuminated box for internal use 82x32 £40 Tel 0121 777 2906

WANTED

STAYCEPT GEL - Any quantity Tel 181 977 2391

NOMAD CASSETTES - Trays and all materials required immediately. Any quantity Tel 0171 722 5221

TENUATE - Dospan tablets, old stock wanted Tel 0171 937 6175

ACCOMMODATION

COSTA DEL SOL - Luxury villa available w/c 14/6, 21/6, 28/6. Almost Free' golf for 4 occupants, £520 pw Tel 01483 [illegible]

ABOUTpeople

Joining the pharmaceutical underground

A Hills pharmacy, built half underground in the depths of Devon, has won a Civic Trust commendation for its environmental 'sensitivity and attention to detail' and, as a result, is being entered into a national architectural competition.

"It is surprisingly bright because the waiting area has a big, glass roof, and it is very warm," says pharmacist Clare Brewer. "Most people come in out of curiosity, and the first thing they comment on is the brightness."

The pharmacy has problems that most others do not, such as rabbits and grasshoppers coming in through open windows.

"Originally, local residents did not want a pharmacy built on this green site. Hills undertook what was an adventurous and environmentally-sensitive design which would satisfy the tight planning restrictions, and proposed putting the pharmacy actually inside the green site," says Hills' pharmacy development manager, David Lancaster.

Underground, the pharmacy comprises of dispensing, retail and waiting areas, with an office and rest room for the pharmacist and three assistants.

The outlet, which opened a year ago, stands next to a cottage hospital and the four-doctor, 7,000-patient Chiddenbrook surgery on a steep south-facing hillside in Crediton, Devon.

The entrance, a circular brickwork drum topped with a lead-covered roof, and a strip of windows below the overhang of the roof are the only outward signs of the building.

● The architect, Smith Roberts Associates, is entering the pharmacy for the Royal Institute of Architects 1997 Architecture Award scheme.

Prescribing a strong cup of coffee

Michies Pharmacy in Union Street, Aberdeen, is a rather unusual place. Instead of stock in the basement, there is a coffee shop.

The success of the 15-year-old, 80-seat cafe has meant that it is shortly being refurbished to accommodate 100.

It has been raising money for medically-orientated charities for several years. Coffee and tea drinkers used to be able to get a second cuppa for free, but it was decided to sell the refill at a reduced rate of 35p and give the proceeds to charity.

"The shop raises between £200 and £500 per month for charities," comments pharmacist proprietor Charles Michie, who owns another six branches. The Union Street outlet is the only one serving coffee.

Each month, money is raised for a different cause selected by the customers to coincide with charity awareness weeks where possible, says Mr Michie.

Proceeds went to the Scottish Motor Neurone Disease Association last month. This was the first charity the shop ever supported, in memory of popular local Aberdeen Football Club director Chris Anderson.

Pre-registration pharmacist Catherine Gaudy of Connors Chemist, Belfast, is one of five winners in Reckitt & Colman's Gaviscon Advance competition. The manufacturer's Northern Ireland territory manager, Brendon Newgent, presents her with £100 of PC World computer equipment vouchers

APPOINTMENTS

Dr George Poste, chairman of research and development at Smithkline Beecham, has been appointed chief science and technology officer.

Pharmacists **Angela Alexander, Douglas Hancox** and **Brian Riley** were elected governors of the College of Pharmacy Practice at the College Day meeting in Kenilworth, Warwickshire on April 24.

AAH Pharmaceuticals has made **David Pepper** its first human resources manager.

Renaat Van den Hooff has been appointed managing director of Johnson & Johnson MSD. His predecessor, **Stephen MacMillan**, has moved to a senior management position with McNeil in the US.

Ian Simpson has been reappointed as professional secretary of the Guild of Hospital Pharmacists for a further three years.

Peter Richards, the managing director of Hoechst Roussel Vet, has been elected chairman of the National Office of Animal Health. Mr Richards has been NOAH vice chairman for the last year.

John Powell, from the Bob Martin Company, has become the organisation's new treasurer. Mr Powell has been on the NOAH board since 1994.

The Oxford Molecular Group has made **Dr Peter Doyle** CBE a non-executive director. Dr Doyle is currently an executive director of Zeneca Group.

Shield Diagnostics Group, manufacturer of human healthcare diagnostics, has appointed **Erik Hornnaes** as a non-executive director. He previously worked as divisional vice president for Abbott Diagnostics.

Konica UK has made a number of organisational changes to improve the level of customer care. **John Townsend** has been promoted to amateur products sales manager. **Mark Wilkins** has become the professional and photo finishing sales manager. **Tony Cornish** has been promoted to Nice Print minilab systems and Konica Photo Express outlets field sales manager. **Nick Cruickshank** has taken over responsibility for the service side of professional division sales.

The president of the London Chinatown Lions Club, pharmacist Robert Kwan (right), presents a cheque for £16,000 to the president of the United Kingdom Federation of Chinese Schools, Dr Joe Au. The donation will be used to train teachers and print Chinese textbooks for pupils at Chinese schools in the UK. The money was raised at a Dragon Boats Fun Day in July last year

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Is there really any doubt which is the most consistently supported home pregnancy test? Predictor is spending an unprecedented 2 million pounds this year on *national* TV, including the new Channel 5. The impact will again be considerable and thousands more will come to appreciate just how perfectly simple, accurate and reliable Predictor is.

New, linked POS materials will prompt in-store recall. A counter unit features a Predictor test demonstrator and *'So you want to have a baby'* leaflets. Shelf edgers and show cards allow you to spread the *'So simple you can't go wrong'* message around your pharmacy. All of which makes one thing certain, Predictor sales will power ahead. And with such strongly predicted sales here's a test for you. Do you have enough stock?

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Predictor is marketed by Chefaro, the OTC healthcare business unit of Akzo Nobel. In serving over 25 countries world-wide, Chefaro are the marketing and distribution experts in self-medication and diagnostics

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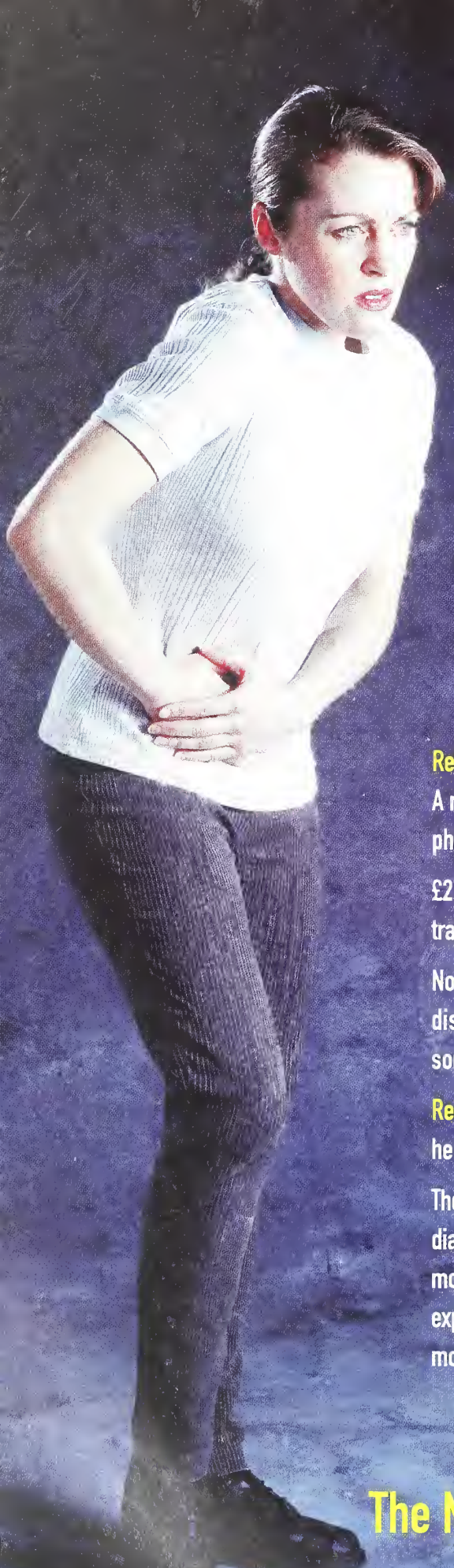

1.6 million reasons to recommend Relaxyl*.

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Relaxyl created the OTC category for Irritable Bowel Syndrome (IBS). A market now worth £1.6 million[1], and growing fast. That's £1.6 million of new pharmacy only sales.

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Presentation: Buff/green hard gelatin capsules for oral administration. Each capsule contains 60mg alverine citrate. Uses: Relaxyl is indicated for the relief of smooth muscle spasm of the gastro-intestinal tract in irritable bowel syndrome. Dosage: Adults, the elderly and children 12 years and over: 1 or 2 capsules, one to three times daily. Not recommended for children under 12 years of age. Contraindications: Cases of paralytic ileus or hypersensitivity to any of the ingredients. Interactions: None. Special Warnings: if symptoms persist or worsen, consult your doctor. Side effects: Possible side effects may include nausea, headache, dizziness, itching, rash and allergic reaction. Effect on ability to drive and operate machinery: None. Incompatibilities: None. Use during pregnancy and lactation: No teratogenic effects have been reported, but caution should be exercised during the first trimester of pregnancy. Overdosage: Hypotension and atropine like toxic effects. Pharmaceutical precautions: Store in a cool dry place below 25°C. Legal category: Pharmacy. Package quantities and price: 18 capsules, £4.59. Product Licence No: PL0322/0072. Date of preparation March 1997. Shelf life: 3 years. Product Licence Holder: Norgine Ltd., Moorhall Road, Harefield, Middlesex UB9 6NS. Distributor: Whitehall Laboratories, Huntercombe Lane South, Taplow, Maidenhead, Berkshire SL6 0PH. *Trade Mark

Reference: 1. IMS data.

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